S. HRG. 109–544

MEDICAID WASTE, FRAUD, AND ABUSE: THREATENING THE HEALTH CARE SAFETY NET

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

JUNE 28 AND 29, 2005

Printed for the use of the Committee on Finance

Public laws/Hearings/Senate/109th Congress/2005/2006 copy 2

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U.S. GOVERNMENT PRINTING OFFICE
29–575—PDF WASHINGTON : 2005

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MEDICAID WASTE, FRAUD, AND ABUSE: THREATENING THE HEALTH CARE SAFETY NET

TUESDAY, JUNE 28, 2005

U.S. Senate,
Committee on Finance,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SH–216, Hart Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Hatch, Baucus, Bingaman, Lincoln, and Wyden.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The Chairman. I am going to call the hearing to order on the issue of Medicaid waste, fraud, and abuse, a point that is threatening the health care safety net.

I thank all of you who will be joining us today as we take a close look at an issue that threatens both the financial sustainability and the quality of care provided by Medicaid.

Over 2 days, we will be looking at the fraud, waste, and abuse problems that plague Medicaid. We will also hear some proposed solutions to reign in problems. I take great pride in exposing problems, fleshing them out, and then working to find solutions.

Two days of hearings present a historic opportunity to address the problems that threaten the long-term sustainability of a very important program, Medicaid, a program that is a safety net for nearly 53 million beneficiaries.

We have a duty to sustain Medicaid for low-income Americans, including children, pregnant women, individuals with disabilities, and the elderly. Coupled with this duty, then, is a duty to all taxpayers to ensure that monies spent on Medicaid are actually spent on patient care, not lost to fraud, waste, and abuse. This hearing is about finding solutions just as much as it is about exposing problems. We have serious work to do, and I hope that everyone will really dig in and do that work.

Medicaid is at risk. In 2003, the Government Accountability Office designated Medicaid a high-risk program because of growing concerns about the quality of Federal oversight and its sheer size: Medicaid spending was nearly $274 billion in fiscal year 2003.

To put that into perspective, that is nearly enough money to cover the entire budget of my State of Iowa for the rest of this century. Making matters more difficult is that spending in Medicaid is expected to double over the next decade.

Based on these numbers alone, if we save even 1 percent of the annual budget of Medicaid, billions in taxpayers' dollars will be saved. Funds then can be reinvested to provide more care to more people.

Fraud, waste, and abuse are not new to government programs, especially health care programs. Because the Medicare and Medicaid programs are so big, even a small amount of fraud, waste, and abuse is a big deal.

In fact, I have been informed that it is virtually impossible to put a number on exactly how much fraud, waste, and abuse occurs in Medicaid. This is an unacceptable condition to be in when we are worried about spending money wisely.

Just as we receive an improper payment rate for Medicare, then I believe we must have an improper payment rate for Medicaid. Some members may not be aware of the volume and size of settlements in cases involving Medicaid scams.

Settlements involving tens, or even hundreds, of millions of dollars are not uncommon. Some companies billing Medicaid are nothing more than phantom stores delivering phantom services and goods, all paid for by Medicaid dollars.

At the end of the day, we are incapable of putting a solid number on how much is actually lost. Given what we do know, the amount lost to fraud, waste, and abuse is staggering. Today, we will begin to assess what we do know, and then call for immediate action. That call should be loud and clear.

Over the next 2 days, we will hear from a number of individuals who have worked hard to document the problems plaguing Medicaid programs. Today, we have two panels. The first will outline the many different players who audit, detect, investigate, prevent, and prosecute fraud, waste, and mismanagement and abuse in Medicaid.

The second panel will start our discussion into areas where abuse occurs, particularly State governments' efforts to maximize the Federal share of Medicaid dollars.

Tomorrow's panel will focus on problems with drug pricing, as well as the issue of shifting assets in order to qualify for Medicaid. Each one of these topics represents real problems, and problems that need to be fixed.

Our first panel includes a new Inspector General for the Department of Health and Human Services; a representative of the Government Accountability Office; a nonprofit organization, Taxpayers Against Fraud; the President of the National Association of Medicaid Fraud Control Units; and a professor at Georgetown who served as Medicaid Director of CMS during the previous administration.

Our second panel today will address various mechanisms that are available to States to increase their Federal share of Medicaid dollars; intergovernmental transfers and Medicaid-maximizing models are going to be discussed.

While States' efforts to provide more services is a noble goal, the Government Accountability Office will note that, in some cases, State consultants may use questionable methods to increase Federal funding and profit from contingency fee arrangements with States. Some of these methods are troubling and threaten long-term sustainability of the Medicaid programs.

I thank these witnesses for their testimony in advance. Hopefully this hearing will kick-start some necessary and healthy changes to the Medicaid program. The status quo threatens the quality of care offered under Medicaid, as well as its long-term financial stability and viability.

Until Senator Baucus gets here, there will be a recess. I would ask everybody to just stay where they are. There is a vote on. Senator Baucus has probably voted by now, and I will meet him on my way over there to vote.

I previously said that I will be necessarily absent for about 20, 25 minutes from this hearing because I have a meeting of the Agriculture Committee simultaneously, with an issue that I have to deal with there. I will be right back, though, and participate. So, there is a temporary recess. Senator Baucus will call the meeting to order.

[Whereupon, at 10:12 a.m., the hearing was recessed.]

After Recess [10:15 a.m.]

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. The hearing will come back to order.

As the Chairman has mentioned, we have a far-reaching set of hearings on Medicaid, and I deeply appreciate the Chairman calling these hearings with all the focus on Medicaid, and frankly all the effort that this Congress must undertake to exercise its oversight responsibilities, to try to help the administration and States ferret out some of the problems, inefficiencies, especially with respect to the rising cost under the Medicare program. I hope that these hearings are sufficiently constructive and help accomplish that objective.

Clearly, Medicaid is a critical part of our health care safety net. More than 53 million Americans depend on Medicaid. Medicaid covers 2 in 5 births, 1 in 4 children, 40 percent of all long-term care services, and protects the most vulnerable among us. Clearly, we must ensure that Medicaid is there for those who need it, and that means ensuring Medicaid's dollars are spent appropriately.

Over the next 2 days, witnesses will tell us that sometimes Medicaid's dollars are not spent appropriately. Whether through inflated pharmacy payments and improper asset transfers or questionable State financing methods, Medicaid money is sometimes misspent.

As rising health care costs strain Federal and State budgets, we cannot afford to waste these precious resources. When Medicaid funds are misspent, Congress should act.

Congress has done so in the past by running into excessive DSH payments in the 1990s, and in recent years by cracking down on upper payment limit schemes. I am not suggesting that our work is done. We should not over-pay for prescription drugs under Medicaid and we should not encourage the creation of cottage industries where consultants are hired by States to maximize Federal Medicaid dollars.

Let us not assume that all growth in Medicaid spending is a result of fraudulent activity. Let us remember that Medicaid spending is growing for many legitimate reasons.

First, increased enrollment. During the last recession, 7.5 million Americans had to turn to Medicaid for their health care. That is 7.5 million people who would probably be uninsured without Medicaid. When times are tough, Medicaid meets the need. That is what it is supposed to do.

Second, Medicaid is growing due to rising costs of long-term care. As America ages, the need for long-term care will grow.

Third, Medicaid is subject to plain, old health care inflation, just like every other insurance plan in this country. To be fair, Medicaid growth is actually lower on a per-person basis than many other forms of insurance. Between 2000 and 2003, a 3-year period, private insurance costs grew over 12 percent per person. For Medicaid during that same period, the growth was much less, not 12 percent, but 6.9.

But Medicaid has room for improvement, just like other forms of health insurance. We need to reward high-quality care, move away from the idea that more care is necessarily better care, and promote evidence-based medicine.

This week, Senator Grassley and I plan to introduce a bill to improve quality and reward high performance in Medicare, and I look forward to working with the Chairman to extend those principles to Medicaid.

We also need more transparency. We need more consistency in Medicaid. This transparency and consistency should extend to State financing arrangements, as well as to the administration's use of Section 1115 waiver authority.

States need to know the rules of financing arrangements up front, and they must have confidence that CMS will judge these arrangements by the same consistent standards. States lack that confidence now.

For example, in 2001, CMS made an effort to close upper payment limit loopholes. But according to the GAO, while CMS was closing loopholes in some States, the agency was allowing other States to engage in the very schemes it was trying to shut down, and at a substantial cost to taxpayers.

In 2003, CMS implemented a new policy on intergovernmental transfers. CMS required States submitting changes to their Medicaid programs to answer a list of questions. Based on their answers, States were told whether or not they were violating the law, but States had no way of knowing whether CMS was applying different rules to different States.

That brings me to waiver authority. I have said it before and I will say it again: CMS has waiver authority for experimentation in Medicaid, not wholesale change. Waiver authority was not designed to create a closed-door process in which stakeholders find out about a waiver only after the ink is dry.

I welcome the opportunity to ensure that Medicaid dollars are spent wisely, and I applaud this committee's longstanding commitment to that end.

But the administration must do its part as well. It must work cooperatively with States to improve Medicaid, it must play a more active role in ensuring that Medicaid is a prudent purchaser of health care, and it must enforce the law consistently, fairly, and uniformly.

I thank our witnesses here for taking their time and effort to join in common effort to find answers to these questions to help get better care under Medicaid, more consistency, more transparency, and not waste taxpayers' dollars.

I would like to now turn to Senator Wyden for any statement he might make.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator WYDEN. Thank you very much, Mr. Chairman. I will be brief, because I think you have summed it up very well. I think the Federal Government, particularly CMS, the Centers for Medicare and Medicaid Services, has been slow to get at this issue of fraud and abuse.

I was struck by an article in the paper this morning. Dr. Mark McClellan, the administrator of the agency, said that they did not have the authority to do required disclosure of the contingent-fee consultants.

What it seems to me the position of the Centers for Medicare and Medicaid Services should have been is, you bet, we have to have this authority. We have to have more tools to go after the kinds of abuses that have been documented.

As far as I can tell, the Federal Government is putting forth a much more substantial effort to root out fraud in Medicare than it is in Medicaid, and it seems to me the Federal Government ought to be both more aggressive and more strategic when it comes to fraud and abuse.

Essentially, the position of the Federal Government, with respect to fraud, is to react after the horses have left the barn, and I do not think that is good enough.

I also intend, Mr. Chairman, over the course of the 2 days, to ask the witnesses their thoughts about Medicaid for the longer term. It seems to me that we are getting a lot of recommendations now in terms of the short term, but under a law that was authored by Senator Hatch and myself, the Health Care that Works for All Americans Act, there is a 14-person citizens working group that is looking at approaches to try to make sure that all Americans have decent and affordable health care.

That means looking beyond, essentially, the next 6 months to what the government ought to be saying in terms of what health care for the poor ought to look like 10, 15 years down the road.

I happen to think that there will be some technological innovations that will make it possible for us to reach more low-income folks with less cost, and I look forward to the hearings.

We have an excellent group of witnesses, many of whom I have worked with, almost since my days as co-director of the Gray Panthers. I think we will get very valuable testimony.

I would urge that we take a longer view to make sure that, as health care evolves over the next 10, 15 years, there is, for the first time, a working group to actually walk the country through the health care choices that are ahead of us, and that we make the best possible choices as it relates to care for the poor.

Starting in October, this country is going to do something it has never done before. For the first time this fall, Americans are actually going to see where the health care dollar goes. It will be printed online. It will be available to the people of this country.

Then there will be an opportunity to walk through the choices that are going to be necessary to get health care for all Americans, and certainly for purposes of today, do a better job of advocating for the needs of low-income folks who, very often, simply fall between the cracks in the system and suffer needlessly.

Thank you, Mr. Chairman. I look forward to it.

Senator BAUCUS. All right. Great.

Now, let us get to the panel, which I will now introduce.

First is Hon. Daniel Levinson, who is appearing before us today. Mr. Levinson is the Inspector General of the Department of Health and Human Services, which obviously is the department that oversees Medicare and Medicaid, and will provide testimony regarding the challenges inherent in overseeing the program.

Next to Mr. Levinson is Leslie Aronovitz. She is Director of Health Care at the Government Accountability Office. Ms. Aronovitz will testify regarding the resources expended on Medicaid fraud, waste, and abuse at the Centers for Medicare and Medicaid Services, otherwise known as CMS.

Next to her is James Moorman. Mr. Moorman is the President and CEO of Taxpayers Against Fraud, which is a nonprofit public interest organization dedicated to combatting fraud against the Federal Government. He will compare fraud and abuse in the Medicaid program with the Medicare program, in addition to providing some statistics on Medicaid fraud recoveries.

Next to Mr. Moorman is Mr. Messuri. He is the President of the National Association of Medicaid Fraud Control Units, and an Assistant Attorney General for Massachusetts. Mr. Messuri is here to discuss Medicaid fraud and abuse from a State perspective, specifically concentrating on the role States play in detecting and preventing fraud.

Next to him is Mr. Westmoreland. Mr. Westmoreland is a research professor at Georgetown University. Mr. Westmoreland is a former Director of Medicaid and State Services at CMS, and is here today to provide testimony regarding the Medicaid program.

So, I will begin with you, Mr. Levinson. You are on.

STATEMENT OF HON. DANIEL LEVINSON, INSPECTOR GENERAL, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. LEVINSON. Thank you, Senator Baucus. Good morning to you and to Senator Wyden.

On behalf of the Office of Inspector General, we are pleased that the committee has devoted these 2 days to address important issues associated with the Medicaid program. We appreciate the opportunity to provide three witnesses during this hearing to discuss these issues.

My testimony describes the roles of our office, the Centers for Medicare and Medicaid Services, the States, and other law enforcement agencies in meeting the challenges of overseeing the Medicaid program.

I will discuss issues associated with identifying and resolving improper payments and fraud. Finally, I will discuss specific vulnerabilities that our work has identified that merit attention and corrective action.

The size of Medicaid, in terms of outlays, has steadily grown over the years to the point where Medicaid now exceeds Medicare in public expenditures. In fiscal year 2004, the Federal share alone of Medicaid exceeded $176 billion. Thus, it is imperative that the program operates effectively, efficiently, and in a manner consistent with Federal and State laws.

Oversight for Medicaid is shared between the Federal and State governments. To ensure that fraudulent payments are identified and resolved, our office maximizes the impact of its resources by proactively coordinating our activities with other Federal and State agencies.

At the Federal level, our office collaborates with the Centers for Medicare and Medicaid Services, the Department of Justice, including the U.S. Attorney's offices, and the FBI, other Federal law enforcement agencies, and certainly the Congress.

At the State level, in addition to our contacts with the State Medicaid agencies, we partner with State auditors on joint projects, and we actively support and oversee the State Medicaid Fraud Control Units.

Almost all of the Medicaid Fraud Control Units receive 75 percent of their funding from a Federal grant that is managed by our office. During fiscal year 2005, our office will administer over $149 million in grant funds to these units.

As the chief investigative agency for HHS programs, including Medicare and Medicaid, our office relies heavily on these State units, which usually report to their States' attorneys general to take the lead on Medicaid provider fraud and patient abuse cases.

While most cases are pursued in the criminal context, we also expect the Medicaid Fraud Control Units to consider whether cases may be pursued under State false claims statutes or the Federal False Claims Act.

In fiscal year 2004, our office conducted joint investigations with the units on 314 criminal cases, 91 civil cases, and achieved 64 convictions. Many of these civil cases, worked in conjunction with the Department of Justice under the Civil False Claims Act, have resulted in significant settlements with pharmaceutical companies. These cases have focused on the pricing and marketing of prescription drugs, practices that have had a substantial impact on Medicaid expenditures in this area.

In addition to identifying fraud and abuse, our office's audits and evaluations are designed to improve program management and increase the accuracy and reasonableness of reimbursement payments.

For example, over the years we have conducted both audits and evaluations pertaining to third party liability. We have found in these reviews that Medicaid inappropriately pays claims and is generally not reimbursed for beneficiaries who have other sources of payment, such as private insurance.

Briefly, I would like to mention two very important issues that will be described in more detail by our office's other witnesses on subsequent panels.

First, we found that States manipulate their ability to make intergovernmental transfers, or IGTs, to inflate the Federal share of Medicaid, contrary to Federal and State sharing principles. This practice often is prevalent with regard to certain enhanced payments to public hospitals and to nursing facilities.

Although regulatory improvements have been made in accordance with our earlier work, additional changes are needed. Our Assistant Inspector General for CMS Audits, George Reeb, will describe the problems that continue to exist and will recommend some ways to correct them.

The second issue I want to mention is Medicaid reimbursements for prescription drugs. Over the past decade, our work has demonstrated that Medicaid pays too much for prescription drugs.

While the Congress' recent action in the MMA changed Medicare's reimbursement to a price based on actual sales, Medicaid's reimbursement continues to be based largely on the same inflated basis that once plagued Medicare.

Tomorrow, our regional Inspector General from Philadelphia, Robert Vito, will describe our extensive body of work on Medicaid drug reimbursements and present the results from three of our most recent reviews. The work provides further evidence that Medicaid pays too much for drugs and that we must find some way to correct this problem.

In short, our office's audits, evaluations, investigations, and intergovernmental collaborations strive to ensure that Medicaid is managed properly. Our goals are for Medicaid to pay a fair price in the marketplace and be protected from those who would abuse and defraud the program.

This concludes my testimony, and I welcome your questions.

Good morning, Mr. Hatch.

Senator HATCH. Thank you so much. Nice to have you here.

[The prepared statement of Mr. Levinson appears in the appendix.]

Senator HATCH. Ms. Aronovitz, we will turn to you.

STATEMENT OF LESLIE ARONOVITZ, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Ms. ARONOVITZ. Good morning, Senator Hatch and Senator Wyden. We are pleased also to be here today as you discuss fraud and abuse control in the Medicaid program.

I would like to start out by defining what we mean by fraud and abuse control activities in Medicaid. We consider fraud and abuse control to be a component of Medicaid program integrity activities, with a particular focus on the propriety of claims made by health care providers.

Another component of program integrity involves financial management oversight, which focuses on the propriety of claims made by States for Federal reimbursement. My colleague, Kathy Allen, will be discussing those issues before you later today.

The fraud and abuse control activities performed by the States constitute the program's front line of defense. Federal statute or regulations require States to check on the legitimacy of providers seeking to enroll in the program, review claims for services billed, recover any over-payments made, and refer cases of suspected fraudulent billing. At the Federal level, CMS is responsible for supporting these State activities and ensuring their compliance with Federal requirements.

In discussing our findings with CMS, officials insist that we are looking at the issue of program integrity too narrowly. We acknowledge that CMS has focused on financial management in recent years and that there are many other Federal players, including the HHS OIG and the Department of Justice, that are involved in pursuing fraud and abuse control activities in Medicaid. However, we continue to believe that there is an important role for CMS, in its partnership with States, to protect the program.

Last year, we reported that the resources CMS allocated to oversee States' programs suggested that CMS's level of effort was disproportionately small relative to the risk of financial loss.

This year, the situation remains the same. We found that the total staff in headquarters and the 10 regional offices devoted to supporting States' fraud and abuse control activities for fiscal year 2005 was about 8.

In addition to limited staffing, CMS's financial support for fraud and abuse control initiatives is uncertain and depends on the priorities set by the agency each year. For example, in fiscal year 2005, CMS funds allocated for Medicaid fraud and abuse were less than half the funds allocated in fiscal year 2004. Given the limited resources for fraud and abuse control, the agency's oversight, information sharing, and technical assistance activities are not thriving.

For example, the frequency of on-site compliance reviews of States' activities remains at about seven or eight States a year. At that rate, for the 50 State programs alone, excluding the territories and the District of Columbia, a State will be visited only about once every 7 years.

One agency initiative that has shown positive results, but appears to be in jeopardy, is one in which CMS has helped nine States coordinate their Medicaid claims data with Medicare claims.

This data match project, called Medi-Medi, enhances efforts to spot fraud schemes and other billing improprieties that often cross program boundaries. CMS posts potential savings of $194 million since the inception of this program, but this program will have to be scaled back or terminated depending on budget priorities set by the agency.

We did note, in Mr. Smith's testimony in the second panel, he did say that he very much supports this activity and would like to continue it. We were very glad to see that, and we hope he can.

Similarly, CMS's other Medicaid fraud and abuse support activities, such as conducting national conferences, regional workshops, and training has been at a standstill for the last 2 years.

Finally, we did not see an organizational commitment or structural arrangement conducive to helping States. In our view, fostering States' use of new and proven techniques to curb provider fraud and abuse is critical. As these techniques help States improve their prevention and detection of billing schemes, a sentinel effect is created so that providers know that they are being watched.

In addition, any costs avoided or monies recovered translate into funds that can be used for health care services. Given the importance of CMS's support for States' anti-fraud and abuse activities, we believe that an increased commitment to helping States fight fraud and abuse is warranted.

This concludes my prepared remarks, and I will be happy to answer any questions.

Senator HATCH. Thank you so much, Ms. Aronovitz.

[The prepared statement of Ms. Aronovitz appears in the appendix.]

Senator HATCH. We will turn to you, Mr. Moorman.

STATEMENT OF JAMES MOORMAN, PRESIDENT AND CEO, TAXPAYERS AGAINST FRAUD, WASHINGTON, DC

Mr. MOORMAN. Thank you, Senator Hatch and Senator Wyden.

Taxpayers Against Fraud very much appreciates the opportunity to testify at this very important hearing on fraud against Medicaid.

The chairman of the committee, Chairman Grassley, was instrumental in the enactment of the 1986 amendments to the False Claims Act. Thanks to Chairman Grassley's efforts, and also the efforts of a number of courageous whistle-blowers, the United States now has the False Claims Act as an effective weapon against fraud. Indeed, I would say the False Claims Act is our most effective weapon against fraud.

Since the enactment of the 1986 amendments, judgments and settlements under the Act have totaled over $14 billion, the majority of which have involved health care fraud.

In the health care area, most of the money returned so far has involved Medicare fraud. However, in the past several years, real progress has been made in going after those that cheat Medicaid. About $1.2 billion has been retrieved for Federal and State Medicaid programs over the past 5 years.

The whistle-blower suits have uncovered Medicaid fraud in a variety of sectors, such as hospitals, nursing homes, drug stores, and clinical labs. However, by far the largest share of recoveries, 80 percent or so, have involved pharmaceutical manufacturers.

TAF has published two reports by Andy Schneider regarding pharmaceutical manufacturer fraud cases. These reports describe 10 settlements involving Medicaid and Medicare in the prior 5 years that returned $2.4 billion.

Recently, the Department of Justice has revealed that it has over 150 additional cases involving pharmaceutical fraud. There is reason to believe that these cases involve many billions of dollars of fraud against Medicaid.

However, these cases are moving very slowly. So far, in fiscal year 2005, Justice has been unable to resolve a single drug maker case. In 2004, Justice resolved only three. There is serious question whether, at the current level of investment, the Department of Justice can actually recover the billions of taxpayer dollars stolen by drug manufacturers from Medicaid.

In an April, 2005 report for Taxpayers Against Fraud, economist Jack Meyer revealed that the Federal Government is getting back $13 for every single dollar spent pursuing health care fraud under the False Claims Act. What the report also reveals is that, despite the obvious success of the False Claims Act, the Justice Department team that pursues the cases is seriously under-funded.

The Civil Division of Justice, which houses the Department's central anti-fraud team, was only given $18 million for civil health care enforcement in 2003, and the number is the same in 2004 and 2005.

In the same year, the Office of Inspector General at the Department of Health and Human Services was spending only about $10 million to support DOJ's health care litigation. The U.S. Attorneys do help out with the False Claims Act cases, but it appears that only a very few offices have pitched in in a serious way. The FBI seems to be AWOL.

In light of the $13 to $1 return, it is very hard to explain why a bigger effort is not being made. You should know that there were only about 60 False Claims Act health care fraud settlements, big and small, settled in 2004, which is par for the course.

This committee can do something to change this situation. The committee has jurisdiction over the Health Care Fraud and Abuse Control, or HCFAC program, that Justice and HHS use to support their health care fraud efforts.

Several hundred million dollars go to Justice, the FBI, and HHS, but very little of that money is being used to fund the crucial False Claims Act cases. This should be changed.

There are two other things the committee could do to encourage suppression of Medicaid fraud. As Chairman Grassley has suggested to the CEOs of a number of drug manufacturers, all companies that receive Medicaid or Medicare funds in excess of a certain number, say a million dollars, should be required to specifically inform all of their employees about the details of the False Claims Act.

At Taxpayers Against Fraud, we believe this reform would focus health care providers on the serious nature of fraud against Medicaid and similar programs and would be a powerful deterrent to future fraudulent behavior.

Last, every State should have its own False Claims Act. A few States already do, and some are using their statutes to attack Medicaid fraud. We believe it should be required that every State that accepts Federal Medicaid money enact a False Claims Act with whistle-blower incentives as strong as those in the Federal False Claims Act.

In conclusion, I believe that with the reforms I have suggested, focused on the Federal Government, State governments, and health care providers, the efforts to curb Medicaid fraud will be significantly enhanced. Thank you, sir.

Senator HATCH. Thank you, Mr. Moorman.

[The prepared statement of Mr. Moorman appears in the appendix.]

Senator HATCH. Mr. Messuri?

STATEMENT OF NICHOLAS MESSURI, PRESIDENT, NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS, AND ASSISTANT ATTORNEY GENERAL, MASSACHUSETTS ATTORNEY GENERAL'S OFFICE, BOSTON, MA

Mr. MESSURI. Thank you, and good morning, Senator Hatch and Senator Wyden. Thank you for the opportunity to appear before you today to discuss the role of the States in investigating and prosecuting Medicaid fraud.

I am very glad to speak to you today as a representative of the National Association of Medicaid Fraud Control Units, which I currently serve as President.

I know these cases firsthand, Senators. I have been Director of the Massachusetts MFCU for 9 years. I have gone into the courtroom and tried health care fraud cases, the likes of which are included in the written testimony that you have received.

As an 18-year career prosecutor, I can tell you firsthand that bringing a paper case against a white collar professional is more difficult than the robbery, rape, and murder cases I tried in the first 8 years of my career.

In my written testimony, I have included successful prosecutions and settlements from MFCUs across the country in 2004. The few sentences attributed to each of those cases do not do justice to the resources it takes, nor the risks involved, for an attorney general to bring these cases into the courtroom.

In 1997, I tried and convicted by jury Dr. Lorin Mimless, a psychiatrist convicted of 260 counts of Medicaid billing fraud and larceny. In 1999, I tried and convicted by jury Dr. Albert Pike, who prescribed unnecessary, addictive drugs to his patients. In 2000, I tried and convicted by jury Dr. Harold Goodman, an orthopedic surgeon, on 29 counts of providing medically unnecessary X-rays and injections. In 2002, I tried and convicted by jury Dr. Kennard Kobrin of ordering unnecessary psychological testing, a conspiracy that he was involved in with several psychologists in his office that he had hired.

These are just examples of the type of prosecutions that are occurring nationwide by State Medicaid Fraud Control Units. In each of these prosecutions, physicians had set in motion or caused millions of dollars in bogus Medicaid payments.

However, the prosecution itself involved only a snapshot inside that courtroom, a sample of their practice; the only way to really keep a trial within a 4- to 6-week period of time.

Each of the defendants was sentenced to jail. The restitution, though, was small compared to the savings going forward by putting these bad doctors out of business.

As much as we attempt to track successes, counting convictions of a law enforcement division, whose job it is to deter future conduct, is an inexact science. However, last year MFCUs obtained 1,160 convictions and recovered $572 million.

Although recoveries are an important mission of the MFCUs, they are asked to do more, and they do do more. The MFCUs were established 28 years ago to protect the Medicaid program, as you know, which administers the provision of health care services to indigent and disabled recipients.

In addition, though, to prosecuting corporate and individual health care providers who commit crimes against the Medicaid program, the MFCUs are responsible for prosecuting companies and individuals who abuse, neglect, or mistreat elderly and disabled residents of long-term care facilities, most of which have been funded extensively, if not exclusively, by the Medicaid program. That is really the basis of the MFCU's jurisdiction.

Congress created these units in 1977, as a result of nursing home abuses that occurred in New York City. Protecting nursing home residents from abuse and/or neglect is an important function for the MFCUs. Determining that link between substandard care and financial fraud is a challenging and often difficult way to investigate health care provider fraud.

In 1999, I tried and convicted Stacy Aruda, a certified nurse's aide, for committing despicable acts of abuse against five Alzheimer's patients. She received a 5-year committed sentence. And as important as that case was, that prosecution did not do anything for my Medicaid recovery column, for those wishing to judge the overall success of the Massachusetts MFCU.

Most Medicaid Fraud Control Units are a division of the Office of the Attorney General. The staff is comprised of Assistant Attorneys General, financial auditors and criminal investigators. More and more Units are employing nurses to assist with the investigations.

The Medicaid Fraud Control Units have State-wide criminal and civil jurisdiction over the investigation of Medicaid health care providers and nursing home patient abuse and neglect. The Medicaid Fraud Control Units act in collaboration with, and as an advisory resource for, the fraud control managers at the Medicaid program, the agency that administers the Medicaid program.

The Medicaid Fraud Control Units establish investigative priorities. They try to identify recurrent fraudulent schemes, trends in unlawful conduct, causes of waste, and abuse, and prevention methods for the protection of health care funds destined for the care of Medicaid recipients.

Members of the Medicaid Fraud Control Units engage in cooperative investigative efforts with a variety of public, State, and Federal entities, including the Board of Registration in medicine, their allied health licensing boards, the State Inspector General's office, the Department of State auditor, the State police and local law enforcement.

The Units have fostered close working relationships with the Federal Department of Justice, the U.S. Attorney's Offices, and the Health and Human Services Office of Inspector General. Through these partnerships, the Units promote coordinated investigations in multi-State actions to safeguard the Medicaid program.

As Mr. Moorman stated, 15 States have their own False Claims Act, complete with discovery provisions. Consistent with its mission to protect the Medicaid program on a State-wide basis, most MFCUs make extensive use of the Grand Jury, as well as statutory and regulatory discovery provisions.

Within the last few years, a great deal of the MFCU's attention has been focused on prescription drug pricing from two very important perspectives: manufacturer price inflation and diversion of prescription drugs for non-medical use by physicians and other providers.

Much of the work is being undertaken with various MFCUs in other States, the U.S. Attorney's Office, the Department of Justice, and the Health and Human Services Office of Inspector General.

The National Association of Medicaid Fraud Control Units does its best to coordinate those multi-State efforts, when all State Medicaid programs are affected by the wrongdoing.

MFCUs do more. They try to work with their single State agencies. They try to talk to program managers. They try to identify problems that are occurring within Medicaid agencies.

None of these IG-type of suggestions or procedures, really aimed at trying to draft regulations in a way to hold providers accountable, are reflected when we look at the MFCUs' recovery list. All of these efforts are efforts that must continue. We can do more. We can work better with our single-State agencies.

A Medicaid Fraud Control Unit that is working with its State agency offers expertise in evaluating the legal viability of potential claims. It offers enforcement resources for prosecuting claims. It offers assistance in creating an effective regulatory framework to prevent fraud, waste, and abuse.

If I were to mention one single thing that I have heard from other MFCU Directors before my testimony here today, they would say that the Medicaid regulations, which prohibit the Units from detecting fraud, the drafting that may have occurred 20, 30, 40 years ago, severely hampers fraud prosecutions that are dependent on data and documentation in order to prove willful intent.

In closing, I want to emphasize that the Medicaid Fraud Control Units continue to play a national leadership role in detecting and prosecuting health care fraud and resident abuse. The Units have been successful in serving as a deterrent to health care fraud and identifying program savings. I thank you very much for the opportunity to appear before you today.

Senator HATCH. Well, thank you, Mr. Messuri.

[The prepared statement of Mr. Messuri appears in the appendix.]

Senator HATCH. We are grateful to have Mr. Tim Westmoreland, who has long served up here on Capitol Hill, and is a friend of my office, and I think the offices of many on this committee, and very much respected by us here on Capitol Hill.

So, we are glad to welcome you back and look forward to hearing your testimony.

STATEMENT OF TIM WESTMORELAND, VISITING PROFESSOR OF LAW AND RESEARCH PROFESSOR OF PUBLIC POLICY, GEORGETOWN UNIVERSITY, WASHINGTON, DC

Professor WESTMORELAND. Senator Hatch and Senator Wyden, thank you for the invitation to testify today. Preparing for this hearing, I realized that it has been 5 years since I was here last, and it is good to be back.

Senator HATCH. Seems like just yesterday to me.

Professor WESTMORELAND. It seems like just yesterday.

Medicaid is doing the catch-up work for the whole broken health care system in the U.S., making up for many shortcomings in

Medicare, private insurance, and a weak economy. Given all of the work that we have asked this program to do, it is performing flexibly and well, and I would note, efficiently.

But I am certain that the program includes waste and fraud, as other witnesses today have certainly shown. I am against those abuses, and I take a back seat to no one in my work against them.

We should fix them as we find them, both to ensure that the public continues to trust the program as efficient and responsive, and to reinvest the money that is saved back into the good work of Medicaid.

Such a prudent course of finding abuse and plowing the savings back into Medicaid is especially needed now because the program is seriously under-financed.

While Medicaid is doing hard work credibly, it is an extremely strained system, especially from a State perspective. The Federal Government should, therefore, be careful about making big changes or fast moves. So much is at stake, the safety net under the rest of American health care, that none of us will be unaffected if the system is pressed too hard.

This is why I find the way that the current administration is now dealing with State financing systems so troubling. Let me provide a little background.

As I mentioned, I was before the committee 5 years ago. I was testifying as the Federal Director of the Medicaid program. I had found out about a State financing system that I believed was inappropriate, aggregated upper payment limits, or the so-called UPL. I was trying to issue a regulation to close abusive UPL schemes down.

UPL was complicated and it was big. The Congressional Budget Office had informally estimated that, if left unchanged, UPL alone would raise Federal costs by more than $100 billion.

But we dealt with it correctly and transparently. We made our views about UPL clear in advance. We met with the OIG and with the GAO and briefed them about the problems we had found and about our proposed solutions. We asked them for their help, and we worked together.

We met with the Governors, with the State legislatures, with hospitals, and with advocates. We met repeatedly with Congressional staff and kept them apprised of our work.

We published a proposed regulation, solicited comments on it, and made the regulation final as a clear and enforceable statement of law. We gave States notice of the new regulation and we gave them a transition period to change their systems. We effectively closed down the major abuses of UPL.

Some estimates show that UPL spending is down 90 percent from its high point, and I am happy to see that the recent OIG report estimates that our actions resulted in $5 billion in Federal savings in this year alone, 5 years after we finished our work.

In dealing with State financing of Medicaid, this administration has done none of that. CMS is making ad hoc and variable decisions about financing rules and waiver conditions.

Waivers, and even State plan amendments, are being held hostage until States give up options that the statute says are State prerogatives. States are being asked to agree to terms and conditions that people do not even understand.

In informal discussions, I found that even Federal auditors do not understand the new terms and what they do or do not include. As Senator Baucus noted, this committee has expressed serious concern that CMS is running Medicaid through waivers that are not transparent in their content or process.

In passing, I would say that your concern about waivers is even more pressing now. The administration is taking over what should be Congress' job, and special terms and conditions are trumping Title 19. The statute and some of its most fundamental promises are being waived away outside of the public view.

But my main point today is that the manner in which CMS is administering State financing rules is directly parallel to treatment of waivers, and it should raise serious and similar concern in this committee.

Decisions worth billions to States, providers, and beneficiaries are being made in private, often as part of large, complex, and unreviewed deals. CMS's methods and policies in this highly technical area are opaque, not transparent. This is not the way to run a program as complex and important as Medicaid.

Let me also remind the committee that running the program this way creates a high risk of increased Federal costs. If a State were to file and win a suit against CMS for acting in an arbitrary and capricious manner by failing to make the formal changes in the regulations, the State would be entitled to claim back payments all the way back to the beginning of the fiscal quarter in which it first filed its State plan amendment. There are billions of dollars at stake.

Going through transparent and formal processes to clear up financial integrity issues is hard work, but it is necessary if the Federal Government is to be a reasonable partner with States, and if the Federal Government is to protect Medicaid and the FSC from abuse.

Finally, I would ask that this committee not approach these issues as a means of cutting the Medicaid budget. Find all the waste, fraud, and abuse that you can, but then plow those savings back into Medicaid. Give the States some dollar-for-dollar relief of the estimated billion dollars of new costs of Medicare Part D, and thus make both the programs as successful as possible; stop the drop in FMAP in the 29 States that are about to be cut; enact the Family Opportunity Act; reduce or eliminate the Medicare waiting period; reduce or eliminate the clawback. These are important measures to protect Medicaid as the safety net under all the rest of American health care, and Medicaid needs all the help it can get.

Thank you.

[The prepared statement of Mr. Westmoreland appears in the appendix.]

Senator HATCH. Thank you, Mr. Westmoreland.

Let me start with you, Ms. Aronovitz. We will have a 5-minute round here, then we will move to our second panel, unless the Chairman comes back and wants to do it otherwise.

In your summary statement on the GAO Medicaid fraud study you state, "The GAO believes that an increased commitment to helping the States combat fraud and abuse in the Medicaid program is warranted." Now, I assume that you believe that CMS needs to increase its commitment in this area.

So, when you were discussing this matter with CMS officials, did your staff ask CMS what type of activities were being conducted agency-wide to combat fraud and abuse in the Medicaid program?

Your statement says that the "dollar and staff resources allocated to compliance reviews suggested that CMS's level of effort was disproportionately small relative to the risk of serious financial loss." I am not sure that is capturing all of the work that CMS has done in this area. So would you mind spending a few minutes on that?

Ms. ARONOVITZ. I am happy to do that. Yes. I think CMS officials feel very strongly that they are doing a tremendous amount of work on looking at financial management issues that have come before this committee in recent years.

Senator HATCH. In listening to you, I was not convinced that your statement, as it was stated, was a fair assessment of CMS's work in the area. According to CMS's staff, there are several departments within the agency that are engaged in that specific area.

Ms. ARONOVITZ. Right.

Senator HATCH. I just want you to answer that.

Ms. ARONOVITZ. Sure. The first line of defense is the States, and the States are doing many, many types of activities in fraud and abuse control. In addition, CMS has a partnership with the HHS OIG and works with the Department of Justice. It also looks at the State surveillance and utilization subsystems.

CMS has as its mission to work with States directly to assure that they are getting the information they need to do the best job they can. This is what we are talking about. It is a narrow piece of a bigger activity that includes checking what the States are doing in terms of collecting Federal reimbursement. CMS does not adequately support what States are doing in terms of provider fraud and abuse control. The States need the Federal Government's help, they need CMS's help, and we think CMS needs to make a bigger commitment to that activity.

Senator HATCH. All right. Now, I notice that you made a distinction between financial oversight activities and activities to help support State anti-fraud efforts. You are making that point. But are they not both part of the same mosaic, and do they not both contribute to the same overall health and integrity of the Medicaid program?

Ms. ARONOVITZ. Absolutely. What we are talking about is apples and oranges, and both apples and oranges are extremely important. We think that CMS needs to do both types of activities. We see it putting a lot of effort into one type of activity, and we would like to encourage it to focus a little bit on the other.

Senator HATCH. But it seems to me that the real issue is a matter of resources. Perhaps this is where Congress could actually be more helpful here, and it is something we need to do.

I understand that your colleague from the GAO will testify that CMS, despite its competing demands and limited resources, is getting a handle on many of the program integrity concerns it has previously raised.

Now, given finite resources, does it not make a lot of sense to focus on the States which really are on the front lines when it comes to identifying fraudulent behavior? After all, do the States not have a stake in this as well? I was very interested in Mr. Messuri's suggestions and comments.

Ms. ARONOVITZ. Right. It does come down to resources. There are certain activities financed from the health care fraud and abuse account, where CMS gets money called "wedge" funds. It has to do a lot of activities with that money. One is to do a measurement of the Medicaid payment error rate.

Another one is this Medi-Medi project, which CMS has been involved in helping States develop. It is a very successful program. But we heard it is in jeopardy because the wedge funds to do this in future years might not be there. They might have to be used for other activities. We hope that CMS will reconsider and try to put resources into that program to sustain it. CMS says it has quite a big return on this investment.

Senator HATCH. Thank you.

Mr. Messuri, my time is just about up, but I want to ask one question of you. I also found your statement about elder abuse quite interesting. Senator Breaux, when he was on this committee, and I introduced the Elder Justice Act in the last two Congresses, and the Senate Finance Committee reported our Elder Justice Act out of the committee last year.

Senator Lincoln and I intend to introduce this legislation in the near future. We hope that we can work with your organization on this bill and that you will give us some help here.

I agree with you, more needs to be done to educate the public and health care professionals about the prevalence of elder abuse. In addition, we included in the Medicare Modernization Act a provision which created a pilot project on background checks of prospective employees of long-term care facilities.

We hope to have this legislation marked up by the Finance Committee in the near future. So, I appreciated your testimony and appreciate the work you do to try to resolve some of the problems.

Mr. MESSURI. Thank you, Senator.

The CHAIRMAN. Thank you, both of you, for watching while I was gone to keep the committee functioning.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

I want to begin with you, Ms. Aronovitz. My sense is, on these fraud issues, the Centers for Medicare and Medicaid Services essentially moves when the horse is out of the barn.

Essentially, after you have had yet another example of the program getting ripped off, you all put out one of your terrific blue books, then the agency reacts. So what I want to see is a much more strategic approach to rooting out this fraud rather than just a reactive approach.

Is there any sense that the Centers for Medicare and Medicaid Services is changing its approach to take a more strategic orientation to this rather than just kind of reacting when we are seeing the program fleeced?

Ms. ARONOVITZ. On the financial management side, the side that you will be talking about in much more detail after this panel, CMS would say that it has hired a lot of new resources to try to look up front at what is going on.

Senator WYDEN. I want to know what you think. Do you think that they are showing that they are going to get out in front of these rip-offs?

Ms. ARONOVITZ. In the area of fraud and abuse control, States would benefit from help from CMS. States need information about what is going on in other States. States should know that CMS will have a continued and major commitment to helping them do their anti-fraud activities. We do not think that that commitment to fraud and abuse control, in terms of helping States, is there.

Senator WYDEN. That still does not really answer my question. I want to make sure that we are looking beyond essentially the next month. What I see is, essentially, a reactive kind of policy.

Did you pick up any evidence that they are thinking longer-term, more strategically? Because if you do not do that, people are constantly just going to game the system. They are always going to find another way to take advantage of taxpayer funds.

Ms. ARONOVITZ. On the side of looking at fraud and abuse control, no, we do not see that, but we do know that it is encouraging States with very little resources.

Senator WYDEN. Thank you.

Let me ask you now about the new policy on intergovernmental transfers. I think it is our view that it is, at best, confusing and inconsistent. States are concerned about discriminatory treatment. There has been bipartisan concern about this on this committee. Do you think the Centers for Medicare and Medicaid Services is consistently applying the requirements with respect to intergovernmental transfers?

Ms. ARONOVITZ. In all due respect, we focused in our statement on the fraud and abuse control, but my colleague, Kathy Allen, who will be on the second panel, will be able to answer that fully for you.

Senator WYDEN. Well, we will be interested in hearing from her on that, because we are certainly concerned about whether it is being consistently applied.

Mr. Westmoreland, has there been anything recently put in place along the lines of what you all did with the upper payment limit abuses? I mean, it seemed to me that you have sort of provided a model for how you could crack down on abuses in an effective kind of way. Are there any recent examples of CMS taking an approach like this?

Professor WESTMORELAND. As I think I say in my full statement, my impression is that it is an ad hoc and a variable approach, that the administration has phrases that they are opposed to.

They are opposed to intergovernmental transfers in favor of certified public expenditures, but no one knows what the administration thinks is wrong with the former, or right with the latter. On several occasions, I found people absolutely unable to explain to me what the terms mean. So, no, sir, I do not think that it is clear or transparent.

Senator WYDEN. I think that is an example of what I mean in terms of thinking strategically. If you see something that has worked, you kind of get up the next morning and say, let us see how we can apply it other areas. I do not see any evidence that that has been done.

I will just note for the record that Ms. Aronovitz shook her head affirmatively on that.

The last question, if I could get it in. Mr. Messuri, you all have talked about your efforts to root out fraud. Of course, the False Claims Act has been effective in prosecuting Medicaid fraud, but only 15 States have their own False Claims statutes.

Let me make sure I understand where you all are at this point. Would you now support the idea of requiring the States to have these False Claims Acts with whistle-blower provisions, and that that be done as something to provide another approach, another foundation for watch-dogging the use of these dollars?

Mr. MESSURI. Yes, Senator Wyden. The Federal Government has made great use of the 1986 Amendments to the Federal False Claims Act in returning health care dollars. No doubt, another tool, a State False Claims Act encouraging whistle-blowers to come forward and report fraud, would be a valuable tool.

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Wyden.

I will just follow up where he left off, because I was going to ask the question both of Mr. Messuri, as well as Mr. Moorman.

So would you answer the question that he just asked, Mr. Moorman, about the impact that it would make if every State had a False Claims Act?

Mr. MOORMAN. Thank you, Senator. Yes. It will have several effects. It closes a loophole, because the Federal False Claims Act does not really reach the State share. They would increase the incentives of whistle-blowers to bring more cases. It gives them procedural flexibility. It brings more resources in.

Some of the States, such as Texas, have made tremendous use of their State False Claims Acts to pursue Medicaid fraud. A False Claims Act will increase the deterrence effect against those who would cheat. So, I think it would be a significant reform and reach about 65 or 70 percent of the State payments that are now not covered by State False Claims Acts.

The CHAIRMAN. All right.

Mr. Levinson, the GAO just testified regarding efforts to detect improper payments back in July of 2004, and noted, “CMS is engaged in several initiatives designed to support States’ program integrity efforts. However, CMS’s oversight of these State efforts is limited.”

So I would like to have you elaborate as to whether CMS’s oversight of integrity efforts has increased or decreased since 2004. Additionally, do you have any recommendations of actions that Congress could take that could help CMS overcome the various problems it faces in preventing improper payment?

Mr. LEVINSON. Mr. Chairman, our office has not done a macro or larger look at CMS operations the way GAO has done recently, so I cannot specifically note exactly how the resource allocation would have occurred on a timeline.

But I do think that the CMS initiative to tackle error rates at the State level is a very important one, the so-called Payment Error Rate Measurement or PERM effort, which I think we are all hopeful would be very beneficial over both the short and the long term.

There are other issues that we have referenced in the course of our testimony, both this morning and what will occur tomorrow. With respect to actually being able to follow the dollars in IGT, these intergovernmental transfers, the fundamental problem is that there is a lack of an audit trail, and we just do not know.

If you ask me if that $176 billion is actually getting to the institutions that are supposed to get the money, and they in turn will be able to deliver the services for our beneficiaries around the country, and I ask that question to our auditors, our auditors cannot say, yes, we know where the money actually was used. It was used in the right place.

So the effort to anchor, to ground, the IGT problem so that we can actually account for the dollars is an important initiative which we think will also be very useful short- and long-term.

On drug pricing, the importance of being able to come up with a formula that is a real-world transaction-based one rather than based on a price list is one that I think holds great promise in terms of savings.

The CHAIRMAN. All right.

My last question, and then I will go to Senator Bingaman, is to Mr. Messuri. We have heard that the Medicaid program is a partnership program between States and the Federal Government, which it obviously has been for 40 years. Could you please tell us what help CMS has been to States in detecting and preventing fraud, waste, and abuse in the Medicaid program?

Mr. MESSURI. Senator, from my chair and my interactions with State Medicaid programs, it seems to be a resource problem. The people that are in the Massachusetts Medicaid program that I deal with on a regular basis are committed to detecting and preventing fraud and abuse.

The problem is, there is just not enough of them. We are talking about a $6 billion program, and you cannot have two or three people that are thinking about these ideas. So, it is a resource problem. Where that direction and leadership comes from, I leave to this committee.

The CHAIRMAN. Thank you.

Senator Bingaman?

Senator BINGAMAN. Thank you very much, Mr. Chairman. I apologize to the witnesses for not being here for your testimony. I was delayed. But I did want to ask, one of the drum beats we hear around here is that the States are sort of gaming the system and loading costs on Medicaid that they should not be, and I understand that argument.

It has been my impression that we do some of that ourselves in the Federal Government. One example is this 2-year waiting period that we have in Medicare for people who are disabled.

I guess I would ask Mr. Westmoreland—I gather you commented on this in your testimony, and I did not get to hear your comments—it would seem that we could save Medicaid some money by dealing with that issue. We could also help a lot of people. I would be interested in any comments you have as to the appropriateness of trying to address that as part of whatever we do.

Professor WESTMORELAND. Well, Senator, one of the things I said was that Medicaid is playing catch-up for a lot of broken places in the national health care system. One of the things I identified as broken is the omissions in the Federal Medicare program, both the cost of duals, which people regularly talk about, but also the cost of what I refer to as duals-in-waiting, those people who want to be duals and are covered only by Medicaid in the meanwhile.

It is estimated that those people cost $10 billion a year. Neither the States, nor those beneficiaries, are as well-served as they could be if Medicare would take up some of that.

And the waiting period, as best I can understand it, is a simple rationing device, in some way delaying expenses to the Federal Government, and in some way, heartlessly, waiting for those people to die in the meanwhile.

Senator BINGAMAN. Now, you say there are 10——

Professor WESTMORELAND. Billion.

Senator BINGAMAN. Ten billion dollars involved here. That is strictly connected with this 2-year disability waiting period.

Professor WESTMORELAND. With the 2-year waiting period. Yes, sir. That is my understanding. I think it is the Commonwealth Foundation estimate.

Senator BINGAMAN. And that is an annual figure?

Professor WESTMORELAND. Yes, sir.

Senator BINGAMAN. All right.

We also had a bill in the last Congress to eliminate the Medicare HMO over-payments to reduce Medicare premiums, and also reduce the deficit, or offset the cost of fixing this waiting period problem. This is something that I believe has been strongly supported by others.

I guess I would ask Ms. Aronovitz to just comment on that legislation. We have not yet re-introduced the bill in this Congress, but we are considering doing so. You are familiar with that.

Ms. ARONOVITZ. I would like to hold off and get back to you. We would like to look at what we have done and what our comments have been so I could give you a complete answer.

Senator BINGAMAN. All right. That is fine.

I will stop with that, Mr. Chairman.

The CHAIRMAN. Thank you very much.

I think it has probably been announced that members who could not be here, or even members who are here, may submit some questions for answer in writing. So, I hope you will respond to that. So, I thank this panel.

I am going to call the second panel.

We have Ms. Kathy Allen, Director of Health Care, the Government Accountability Office. Ms. Allen is here to provide testimony regarding use of Medicaid consultants by States as a means to increase Federal reimbursement for Medicaid. In addition to that testimony, she is going to release a blue-cover report on these contingency fee consultants. I thank Ms. Allen and her staff for preparing this report in time for this hearing, because she had to speed up the time to make it available.

The second witness is Mr. Dennis Smith, Director of the Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services. Mr. Smith's testimony regards CMS and the resources dedicated to identifying fraud and preventing it. Mr. Smith will also discuss his agency's effort to monitor intergovernmental transfers.

The third witness is Ms. Barbara Edwards, Deputy Director, Office of Ohio Health Plans. In this capacity, Ms. Edwards is director of the Ohio Medicaid program. Ms. Edwards will testify about Medicaid consultants from the State perspective and her experience with consultants as a State Medicaid director.

George Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits, within the Office of Inspector General of HHS, will testify regarding the various types of mechanisms States have used in order to maximize their Federal funding for Medicaid. Mr. Reeb will also discuss the impact that these mechanisms have on the quality of care for Medicaid beneficiaries residing in nursing homes.

Chuck Milligan, our final witness, is executive director of the Center for Health Program Development and Management at the University of Maryland Baltimore County. Mr. Milligan is here to provide testimony discussing the reasons and necessities for these various revenue maximization strategies.

So, we will go in the order that you were introduced. That is from my left to my right. So, Ms. Allen, would you please start?

STATEMENT OF KATHRYN ALLEN, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Ms. ALLEN. Thank you. Mr. Chairman and members of the committee, I thank you for the opportunity to be here today as you address this important issue of State efforts to maximize Federal Medicaid reimbursements and the associated effects on the Federal share of the program.

As you know, GAO has completed a considerable body of work over several years on Medicaid financing issues. In prior work, we have reported on questionable methods that some States have used to inappropriately increase the Federal share of the Medicaid program.

Some States, for example, have made large payments to certain providers, such as nursing homes that are operated by local governments, which have greatly exceeded the established Medicaid payment rate. These transactions, these payments, create the illusion of a valid payment for provider services. In reality, the payments are often only temporary because States require that all or most of the money be returned through intergovernmental transfers, or IGTs.

We believe that such schemes violate the fiscal integrity of the Federal/State Medicaid partnership in at least three ways. First, these practices effectively increase the Federal matching rate beyond that which is established in law by increasing Federal spending, while State spending remains unchanged, or at times even decreases.

Second, there is no assurance that these increased Federal funds are used for Medicaid purposes, since States can, and do, use the funds returned to them at their own discretion.

Third, these practices enable States to pay a few public providers amounts that far exceed the cost of services provided, which is inconsistent with the statutory requirement that Medicaid payment be consistent with economy and efficiency.

Today, we are issuing a report that was conducted at the request of the Chairman which deals with States' use of contingency fee consultants to help them maximize Federal Medicaid reimbursement.

I need to preface our findings, however, with a very important context. Contracting with consultants to carry out governmental activities is common at Federal, State, and local levels of government.

With regard to Medicaid, States often hire consultants to help them perform a number of valid programmatic functions, such as identifying and implementing ways to obtain allowable Federal matching funds.

States may choose to pay consultants on a contingency fee basis, that is, a percentage of the additional Federal funds that are generated for the State. Generally, however, the contingency fees cannot be claimed for Federal matching funds. States must pay these fees from their own resources.

I need to be clear on one point: any State's use of consultants or any associated growth in Federal reimbursements is not problematic in and of itself, as long as States administer their programs within the framework of Federal law, regulation, and policy.

Now, in our most recent work we found that, according to CMS's own internal survey, States are making increased use of contingency fee consultants in their Medicaid programs: 34 States in 2004, an increase from 10 States just 2 years ago. In the two States that we reviewed, consultants helped to generate more than $2 billion in additional Federal funds over their last 5 years.

In reviewing individual consultant-led projects and associated claims in five specific areas of Medicaid services, we identified claims that were problematic in two key respects.

First, some were inconsistent with Federal law, appeared to be inconsistent with current CMS policy, or otherwise compromised the financial integrity of the Medicaid program.

Second, some involved claims for Federal matching funds for services that were provided by other State or local government agencies, thus facilitating State efforts to shift their share of costs to the Federal Government.

We found that problematic claims tended to be in areas where Federal requirements were inconsistently applied, evolving, or were not specific. The lack of clear Federal guidance has allowed States to develop new arrangements, or to continue existing ones, that take advantage of ambiguity and that result in considerable additional cost to the Federal Government.

I would also note, however, that although the focus of our work was on contingency fee consultants, we concluded that problematic claims are not confined to situations involving consultants. We found that other States have undertaken similar projects on their own without consultants.

In conclusion, I would like to acknowledge that Congress and CMS have taken many important steps over the years to help curb inappropriate Medicaid financing schemes as they have come to light.

CMS has recently stepped up its efforts in this regard, working with States to eliminate certain unacceptable practices. In our view, however, CMS has the opportunity, if not the obligation, to do more to clarify, communicate, and consistently apply its policies regarding certain areas that both they, and we, have identified as high risk to the program.

In this vein, our report being issued today includes recommendations to CMS intended to help the agency's oversight of States' use of consultants.

Our report also notes an earlier recommendation that we made to Congress that deals with prohibiting Federal Medicaid funds for payments to government providers that exceed their costs.

This concludes my statement.

Senator HATCH. Well, thank you, Ms. Allen.

[The prepared statement of Ms. Allen appears in the appendix.]

Senator HATCH. Mr. Smith, we will turn to you.

STATEMENT OF DENNIS SMITH, DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS, CENTERS FOR MEDICARE AND MEDICAID SERVICES, WASHINGTON, DC

Mr. SMITH. Thank you, Senator. It is a great honor and pleasure to be with you today in the committee, and with Senator Bingaman. Thank you for inviting me.

At the outset, I would like to say that perhaps the title of the previous GAO study about CMS's commitment might be somewhat of concern to the committee, and I want to assure you that our commitment to safeguarding the integrity of the Medicaid program is strong. We also believe it should be measured by results.

I think, as the previous panel conceded, they looked at it in a very narrow way. We believe we have many partners in the fight against fraud and abuse in the Medicaid program, starting with the States, that are our partners, and including the Office of Inspector General, the MFCUs, the Department of Justice, et cetera. We do have many partners in all of this.

We are pleased to report that our efforts have yielded results, and increasing results, and we believe they will continue to do so.

In regard to the issue of financing, my colleague, Kathy Allen, from GAO, spoke about the State financing of the Medicaid program going back a number of years. I believe GAO issued a report as early as 1994 on State financing issues.

So, in many respects, what we have been doing over these past years is in areas that have been identified by the GAO and by the Office of Inspector General, and we have been putting measures in place and our practices in place to review the State plan amendments against those standards to understand what these financing arrangements are.

In many respects, people have portrayed these as very complicated and complex. Medicaid financing certainly is complicated and complex, but to a large extent, it is simply asking the questions of how dollars flow, how payments are made, and whether or not the payments that the Federal Government makes actually stay with the providers that have provided the services.

I believe that tomorrow's panel—at least one witness—will talk about a nursing home that had quality of care issues over the past few years, and in fact was returning substantial supplemental payments that had been paid through the Medicaid program back to the State.

So, in Medicaid, the program works through, and speaks through, State plan amendments. We believe very strongly that it is appropriate for us to ask the funding questions of the States, such as: how does your State plan amendment work; what is the source of the State's share of the funding; and does the money stay with the provider?

It is our goal—and we share your goal, Mr. Chairman—that Medicaid expenditures should actually stay with the provider that provided the service. That is our policy, and we have been working with the States to assure that that is what, indeed, happens.

I am pleased to report to you, Mr. Chairman, that in April of 2004, the Administrator, Dr. Mark McClellan, wrote you a letter saying that we had identified potential recycling situations in 30 States, and that 23 States had worked with us to remove these recycling amendments. Oftentimes these are identified through supplemental payments, that is, additional payments above the rates that were paid for the service.

I am pleased to tell you that that number has now increased to 26 States that have worked with us to end those types of financing arrangements, leaving the number of States now with questionable recycling at a total of 7 States.

In other areas, it is important to look at the entire picture of our efforts on financial management and program integrity, because we believe very strongly that they go together.

The State collections of over-payments as a result of fraud and abuse efforts in 2004 were $190 million, of which the Federal share was $111 million. In 1997, CMS issued 11 disallowance statements to the States, totaling $13 million: the disallowance being that the States had made an improper payment, in our estimation, and we were asking for that money back.

In 1998, HCFA issued three such disallowance letters, totaling $40 million. In 1999, HCFA issued three such disallowance letters, totaling $1.7 million.

In 2004, we issued 40 letters, totaling $218 million; in 2002, 13 letters, totaling $272 million. So, I want to assure you, our commitment to program integrity is strong.

With regard to third party liability collections and cost avoidance, the previous panel spoke of the SUR system, the Surveillance and Utilization Review subsystem, which is part of the claims processing computer systems. We have spent $1.5 billion building those systems.

I am very pleased to tell you that the third party liability collections and cost avoidances made possible through those systems are at an all-time high. Together, those collections and cost avoidances now total over $34 billion.

The three particular issues that the GAO has focused on in the most recent report being released today are targeted case management, rehabilitation services, and school-based claims. I want to assure you that CMS has taken action on each of these areas over the past several years. We have also made it part of the President's budget by making recommendations to further tighten up the definitions of these services.

I believe we are in agreement, GAO and CMS, that this is an area that does need to be paid attention to and given greater focus, to avoid inappropriate payments. On that, we are in agreement. We have already taken action against States in each of these areas.

We have also developed an internal tool that we call TIIPPS, Transactions Information Inquiry and Program Performance System, that we have built, using $3 million, to integrate the different information and data systems that we have.

The State plan amendments, the MMIS systems, information on the budget that comes through the CMS 37s and 64s, the information that comes through Medicaid's statistical information system, we link them together so our managers can look at the entire system at the same time and identify areas that need attention.

Finally, let me also mention the concern of whether or not we have applied our policies consistently across the States. One of the most important things that we see, and having served in a State previously, I understand this, is a concern that the Federal Government was not dealing fairly with States and was giving inconsistent guidance.

To avoid that, one of our most important developments has been to form one team that reviews all of our State financing plan amendments. This team, now called the Division of Reimbursement and State Activities, has reviewed over 800 State plan amendments, and we welcome GAO's review of our procedures and how we have dealt with all of those 800 State plan amendments.

I feel very confident that they will validate that our policies are being applied fairly and consistently. This is an area where the consistency is there. Instead of having each region review those, now one team reviews them and is in a position to make uniform decisions.

Second, the previous panel also talked about, I believe, Senator Wyden's concern about the future. What is going to come up next? We have hired 97 FTEs as part of this one unit to identify prospectively what new ideas are being generated out there, often by consultants who are asking, how can you bill the Medicaid system for this, et cetera?

So, those FTEs, a large part of their responsibility is to understand what is going on in the State and help prevent problems before they get traction in the Medicaid program.

Thank you again for inviting me. I look forward to your questions. Again, I do want to assure you, Mr. Chairman, of our commitment to program integrity and financial management in the Medicaid program.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Smith appears in the appendix.]

The CHAIRMAN. Now we go to Ms. Edwards.

STATEMENT OF BARBARA EDWARDS, MEDICAID DIRECTOR, OFFICE OF OHIO HEALTH PLANS, COLUMBUS, OH

Ms. EDWARDS. Chairman Grassley, members of the committee, thank you for the opportunity to testify today. I have served as Ohio's Medicaid Director for the last 8 years, and have, in fact, seen many iterations of the issues that are being discussed by the panel today.

Ohio, like many States, uses intergovernmental transfers as a mechanism to facilitate a small portion of Medicaid financing involving public providers of Medicaid services. I am pleased to tell you that CMS has not identified Ohio as a State that may be making improper use of intergovernmental transfers under Medicaid.

All of the dollars spent in the Ohio program are used to provide or support allowable health care services or programs to real Medicaid enrollees. States generally use IGTs or other revenue strategies with Federal approval or under the guidance of explicit Federal regulations. These financing strategies are often appropriate ways for States to accomplish the goals of the Medicaid health plan.

My plea to this committee is to keep the issue of financing strategies at the State level in the proper context. State efforts to maximize Federal matching dollars are not a problem in and of themselves. They are, in most cases, a symptom of much more fundamental program challenges that State Medicaid directors, State Governors, and our legislators are facing every day. We are struggling with financing the health care costs of the sickest, poorest, and most disabled populations in our States.

It is important to keep in mind that 75 percent of all of the dollars spent in Medicaid are for populations that are aged, blind, or disabled, even though they only make up about 25 percent of the enrolled population. Over 40 percent of State spending, total Medicaid spending, is for people that are insured by Medicare.

The Medicaid program is spending almost half of the program dollars on people that are already insured through Medicare, and that is a population that is growing and those costs are growing.

I think, as a former panelist said, the Part D program, the new pharmacy program under Part D for Medicare, is going to, for many States, including Ohio, cost the States more money to support the cost of pharmacy for the dually eligible population. We have to find those revenues someplace to support those obligations.

States have been aggressive in pursuing cost containment in Medicaid, saving both State and Federal taxpayers billions of dollars in our efforts. In spite of our success with keeping the rate of growth in Medicaid spending below the rate of health care cost growth in the private sector, the rate of spending for Medicaid continues to grow at more than twice the rate that State revenues are growing, so we have a terrible challenge in finding ways to continue to fund these programs without simply beginning to take them apart.

Little wonder then, when consultants come to town and offer that there are solutions because there are untapped Federal resources still available to States if we would simply think about our programs differently, that legislators, that OBM directors, that Governors, and even Medicaid directors sit up and take notice and are at least willing to sit down and have a conversation.

It is true. A couple of years ago, we probably had at least five different consulting companies making the rounds in Ohio to all of our leadership, offering hundreds of millions of dollars in potential revenue that would help offset what otherwise might be cuts to

Medicaid, or if the State funded the Medicaid dollars, cuts to the rest of the State services, including primary and secondary education.

Ohio is not a State that has chosen to hire these contractors on a blank basis under a contingency fee, but most of them, in fact, have offered to do this work under contingency, taking their funding out of the revenue that is generated.

When CMS clarified a few years ago that they would not approve Federal reimbursement on a contingency basis for this kind of a contract, the consultants, in fact, fairly quickly said to States, just pay us out of the State dollars; it will be worth it because the revenue growth from the Federal side will offset the cost at the State level.

Ohio has not done this, for a couple of reasons. One, in many cases, the ideas that the consultants were discussing were strategies we already have used appropriately within our program. Maximizing the Federal matching dollar is fiscally prudent for States, it is not criminal. Other strategies that consultants were pursuing, we thought, did not pass the "smell" test.

What we are looking for is reliable, predictable revenue streams into the future. If we are going to, in fact, build a fundamental program like this health plan at the State level, we need to know the financing is really going to be there.

I would also point out that the consultants that have been most engaged in this issue in the State of Ohio have not been folks that have been working for the State Medicaid agency, they have been folks that have been hired by the local schools, by the local health department, by the mental health boards at the community level, by the Department of Youth Services.

Other agencies have hired consultants as well to help them create strategies to approach Medicaid and request program redesign in order to better attain Federal matching dollars for what is argued to be legitimate funding.

I want to be clear: I firmly believe that States are obliged to be fiscally responsible in our relationship with the Federal Medicaid program. In order to accomplish the goal, State Medicaid directors ask that we have clear standards, formally promulgated rules that spell out the parameters of our fiscal responsibilities, and consistent application of the rules.

Changes to rules should not be applied retroactively, and, if formerly allowable models must be replaced, it is important to recognize that States must have time to transition to alternative funding strategies.

The reality is that, for most States, any reduction in Federal Medicaid revenue will leave States no choice but to cut programs and services to the vulnerable citizens that Medicaid is intended to serve.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Ms. Edwards.

[The prepared statement of Ms. Edwards appears in the appendix.]

The CHAIRMAN. Now, Mr. Reeb?

STATEMENT OF GEORGE M. REEB, ASSISTANT INSPECTOR GENERAL FOR THE CENTERS FOR MEDICARE AND MEDICAID AUDITS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. Reeb. Good morning, Mr. Chairman and members of the committee. I am here today to discuss the States' use of financing mechanisms that serve to shift the costs of the Medicaid program to the Federal Government, contrary to statutory Federal and State sharing formulas.

We have noted practices whereby, once the Federal share is received, States sometimes use intergovernmental transfers, referred to as IGTs, to divert funds away from their intended Medicaid purpose.

In fact, when States divert funds in a manner I will describe, a State's share of the Medicaid program inappropriately declines and the Federal share increases. Frequently, the funds derived from these financing mechanisms become commingled in general revenue accounts within the State, where they can be used for any purpose, possibly non-Medicaid-related.

In particular, I will describe the negative implications such practices may have for the quality of care for Medicaid beneficiaries residing in local public nursing facilities.

The most conspicuous use of the IGT mechanism in recent years has centered on the enhanced payments available under the upper payment limit rules, as has been discussed several times this morning.

The upper payment limit is an estimate of the maximum amount that will be paid to a category of Medicaid providers under Medicare payment principles. Some of our recent audits have explored States' use of IGTs, with some or all of the UPL-enhanced funds that were directed to local public nursing facilities returned to the States instead of being retained at the facilities for the care of the Medicaid patients.

One such example involves Medicaid's combined per diem and UPL payments that were made to Albany County Nursing Home in New York. These payments, made over a 3-year period that we reviewed, were more than adequate to cover the nursing facility's operating costs.

However, after the nursing home returned 90 percent of the upper payment limit-enhanced funds to the county and the State, the net Medicaid payment that was retained by the facility was $22 million less than the facility's total Medicaid operating cost for the same 3-year period.

This diversion of funds took place despite the fact that the nursing home was understaffed and had received an "immediate jeopardy" rating from the State Department of Health, which is the most unfavorable rating that could be issued.

We made recommendations based on our past audits of UPL-enhanced payments, which, if implemented, we believe would help curb the inappropriate use of the IGT transactions. For example, we believe there should be a facility-specific limit, based on the actual cost reports of each targeted facility, to cap the amount of the enhanced payments that could be sent to a single facility.

States should be required to allow public providers to retain their upper payment limit funds to provide health care services to Medicaid beneficiaries. Any Medicaid funds which are returned to the State by these public providers shall be declared refunds, with the Federal share of the refund returned to the Federal Government.

These State manipulations of the UPL-enhanced payment transactions are but a continuation of creative financing mechanisms that States started with provider tax and donation programs more than 15 years ago.

These earlier programs and the present process of using UPL-enhanced payments to inflate the Federal share, are little more than carefully crafted financing techniques. Although these financing techniques differ in some respects, the constant is that the Federal Government always loses and the States always profit.

Currently, we are seeing similar cost-shifting techniques at work in other Medicaid benefit areas as well, and I mentioned some of those within my written testimony.

We foresee the possibility that all types of public Medicaid providers could be used by the States to maximize Federal revenues, thereby circumventing the statutory Federal/State sharing formulas and weakening program accountability.

Our studies raised serious concerns that States' accountability for the Medicaid programs needs improvement. Policymakers need assurance that the Medicaid funds are actually used for the intended purposes, and there should be a clear trail of responsibility within the State as to who is accountable for the proper expenditure of the Medicaid funds.

This concludes my testimony. I welcome any questions you may have.

The CHAIRMAN. Thank you, Mr. Reeb.

[The prepared statement of Mr. Reeb appears in the appendix.]

The CHAIRMAN. Now, Mr. Milligan?

STATEMENT OF CHUCK MILLIGAN, EXECUTIVE DIRECTOR, CENTER FOR HEALTH PROGRAM DEVELOPMENT AND MANAGEMENT, UNIVERSITY OF MARYLAND BALTIMORE COUNTY, BALTIMORE, MD

Mr. MILLIGAN. Thank you very much. I would like to just say at the outset that I am a recovering State Medicaid Director from New Mexico. It is good to see Senator Bingaman again. I appreciate the opportunity to fulfill my ongoing community service obligations. [Laughter.]

In my remarks, I am going to focus on IGT and UPL. I am happy to answer questions about school-based services or other areas. But, first, I would like to just focus on four points.

The first is that the vast majority of current intergovernmental arrangements do comply with Federal laws and regulations, and also comply with State Medicaid plans approved by CMS. So, I do want to acknowledge, and I think the point has been made by several others, that most of the arrangements, the vast majority, do comply with current Federal law, Federal regulations, and approved State plans.

Second, I think it is fair to acknowledge that these arrangements give rise to the risk of fraud and abuse, and it is very appropriate for Congress and for the administration to focus resources and attention on this. Because, unlike a lot of other arrangements, when State and local governmental entities act as both payor and provider, the normal arm's-length relationships that exist between an insurer and a provider are not present in some of those arrangements. However, the scale of the potential problem is not known at this point, and I would strongly caution Congress and the administration not to extrapolate too much from anecdotes to settle too early on an arbitrary budget figure.

The third point I would like to make is that, as I have noted in my written testimony, it is going to be exceptionally difficult for the Federal Government to enforce certain reforms that have been described on this panel to crack down on potential IGT and UPL abuse.

For example, to prevent IGT abuse, which is sometimes known as the recycling of funds, the Federal Government is going to need to trace the flow of funds from a public provider, like a county hospital, back to a county government, for example, or a State hospital to a State government.

The traffic of dollars that operates between county hospitals and county governments or State hospitals and a State public health agency is numerous, relating to capital expenditures, public employee expenditures, and other areas, and I think it is going to be very difficult to isolate potential Medicaid recycling.

For example, if Medicaid recycling, in fact, was prohibited and barred and it was possible to enforce that, I am not sure how county-level providers and governments could not work around that by returning commercial insurance payments which are legitimately billed by county hospitals.

In short, I think this would be the first time that the enforcement mechanism would seek to trace the dollars after receipt by a provider, and I think that that is very difficult, administratively, to enforce.

With respect to the UPL test, this is also going to be very difficult to enforce if it is premised on a cost-based reimbursement model, much like the Boren amendment that was repealed in the 1997 Balanced Budget Act.

What that would do is recreate, in a lot of ways, an audited cost reporting mechanism which is administratively burdensome, administratively expensive, and, in fact, often rewards inefficiency by incentivizing providers to drive up their cost structure to generate additional reimbursement.

The other point I would like to make with respect to UPL is that, because Medicare can pay above a provider's costs, it is not clear to me why Medicaid cannot pay at that same Medicare level.

In other words, if cost-based reimbursement is considered to be the appropriate governmental reimbursement structure, Medicare ought to be part of that discussion. I do not personally understand the logic behind Medicaid and Medicare payments not being linked in that mechanism.

But, fourth, I would like to suggest a potentially better version that would both protect the integrity of Federal funds and try to address some of the underlying dynamics in this situation. It has two parts.

The first is, the incentive that exists for States and local government to create some of these IGT and UPL arrangements is driven largely by the rapid growth in Medicaid enrollment and the uninsured, and programs like the disproportionate share hospital payment, or DSH, have not been indexed to keep up with those levels.

If DSH and programs like that were indexed more closely to Medicaid enrollment and the rate of uninsured, some of the incentives underneath these structures would go away. That would be an increased cost to the Federal Government.

I would like to suggest an alternative to decrease costs. Right now, States and local governments operate essentially with two-tier payment structures, one payment rate structure for private providers like private hospitals, and a second structure for public providers like public hospitals.

I think that those rate structures could be brought more in line, and, if DSH was indexed—and programs like DSH—to protect safety net providers that serve this high Medicaid enrollment and high rate of uninsured, if those programs were properly indexed to those levels, the incentives would go away, and I think States would be more likely to accept claims-level, payment-level, reforms.

I will conclude my comments there, and I look forward to any questions you might have.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Milligan appears in the appendix.]

The CHAIRMAN. What I would like to do here is have Senator Hatch, Senator Bingaman, and Senator Lincoln, assuming that you only need one round, to ask your questions first, then I would finish up. Is one round all you need?

Senator HATCH. It is all I need.

The CHAIRMAN. All right.

Then Senator Hatch, then Senator Bingaman, and then Senator Lincoln.

Senator HATCH. Well, thank you, Senator Grassley.

Let me just talk to you for a minute, Mr. Smith. How do you respond to GAO's finding presented in the previous panel's testimony that CMS has a "limited institutional commitment to Medicaid fraud and abuse control activities," and that "CMS lacks a strategic plan to drive its Medicaid anti-fraud and abuse operations." I want to give you an opportunity to answer that.

Mr. SMITH. Thank you, Senator. With all due respect to our colleagues at GAO, we just substantially disagree with that assessment. As I said, I think that they have taken a very narrow look at the program, a very narrow look at a singular part of resources, and have not looked at everything that is going on in the Medicaid program to ensure program integrity and to assure that Federal funds are being spent correctly.

Senator HATCH. As I understand it, in almost all cases, CMS has been concerned with whether the provider has a specific agreement in writing with the State that requires the provider to return the funds to the State or no payment is made to the provider. Am I right about that?

Mr. SMITH. You are correct, Senator. Again, our concern is that Medicaid dollars that are claimed should go to the provider who provided the service. As I said, with due respect to my colleague on the end, some of these things are not all that difficult to find, assuming that CMS is doing its job to ask the appropriate questions about State plan amendments, to say, "Where do the dollars go?" As I said, in these arrangements, these are supplemental payments. These were specifically put there in place and they are relatively easy to identify.

Senator HATCH. Well, I understand that in many cases the States simply transfer the funds to an account in the name of the provider, and then immediately transfer back the specified amount to the State. That is what the provider does.

Mr. SMITH. You are correct, Senator, that has been a practice.

Senator HATCH. Well, the provider has no control over the funds. Is that right?

Mr. SMITH. I think a question we have asked is: where is the authority to require a provider to return that money in the program? With regard to our work in identifying those arrangements, in the States in which those arrangements had sort of increased over time, we have been successful in bringing those arrangements to an end.

Senator HATCH. Would it be fair to say that such payments are really illusory, in the sense that they do not go toward providing allowable services for Medicaid eligibles?

Mr. SMITH. I would agree with you, Senator.

Senator HATCH. All right.

Now, I understand from GAO's testimony that they have repeatedly recommended action by Congress to close down States' opportunities to inappropriately maximize Federal dollars. I believe CMS has already made great progress to limit financing abuses.

Now, are there any changes in the statute which would help CMS in its efforts to ensure proper financing and payments under the Medicaid program?

Mr. SMITH. Senator, we believe what we are doing is appropriate and within our authority to do. We would, at the same time, urge Congress to act, as well, to make certain that these enforcement efforts are permanent, by doing that through the statute so that they survive into the future.

Senator HATCH. Now, I have heard a lot about bad IGTs. First, can you tell me what a bad IGT is?

Mr. SMITH. Thank you, Senator. We do distinguish between permissible and impermissible intergovernmental transfers. The Medicaid statute allows the State to share its share of the Medicaid program with local government entities, so an appropriation might have been to a different agency, such as a mental health agency, or a county has transferred tax dollars to the State to share in the cost of the program. We do not quarrel with that.

Senator HATCH. But, second, what is the impact on the Federal Treasury of these arrangements?

Mr. SMITH. The impact for an impermissible arrangement is, you have raised the Federal match rate, which we do not believe is consistent with the statute.

Senator HATCH. Can you outline for me exactly what steps you have taken to ensure that Federal Medicaid payments reflect an appropriate match for the States' Medicaid expenditures for Medicaid services?

Mr. SMITH. Through our State plan amendment review, Senator, we are assuring an appropriate match by questioning how these financing arrangements work, and to the extent to which they exist, requiring the States to bring them to an end.

Senator HATCH. My time is up, Mr. Chairman. I am sorry I did not have more time.

The CHAIRMAN. Yes. Senator Bingaman?

Senator BINGAMAN. Thank you, Mr. Chairman.

Let me also ask Mr. Smith a few questions here. As I understand it, in the budget that the President submitted this year, the administration's budget, there are proposed spending cuts of $20 billion in Medicaid. That is over 5 years.

The explanation is that two-thirds of those would come from what is called program integrity initiatives, and you have seven of those, as I understand it, program integrity initiative proposals.

My impression is, we do not have a lot of specifics about what it is you are recommending Congress enact in order to accomplish any of those, or how much of that savings is achieved by each of the various proposals, and also data, State by State, as to what the impact might be on States if we went ahead and took your recommendations. Is that something that you can provide us? Is that information that is available, State-by-State data?

Mr. SMITH. Senator, we would be delighted to work with you on those legislative proposals. Part of them, obviously, have changed even since the introduction of the President's budget, in that we are now down to seven States with these arrangements. But in terms of the other program integrity issues, we would be happy to work with you.

Senator BINGAMAN. All right. That would be useful, and particularly, as I say, the State-by-State impact data for the various proposals so we know what we are talking about. That would be useful.

Mr. SMITH. Certainly, Senator. Those initiatives simply result in the States being restored to the appropriate match rate, and ensure that we are paying for things that are appropriate to the Medicaid program, and we are not duplicating payments that have been made somewhere else, et cetera.

As I recall, BBA 1997 was an amendment from Senator Bob Graham from Florida, an amendment on program integrity that prohibited the Federal Government from matching expenditures that are outside the Medicaid program or not for things that are not covered by the State plan. So, we see our work as being consistent with that provision.

Senator BINGAMAN. All right.

Let me ask Ms. Allen, your report cites the inconsistent application of CMS enforcement policy as playing a role in increasing the risk of some of these troublesome State financing claims. Do you think that something could be addressed by a CMS rule?

I mean, instead of having just to go State by State to figure out and respond to each, could we have a rule issued by CMS that would provide States with clear notice of what is abusive practice and what is not?

Ms. ALLEN. Yes. We do believe that that is a possibility. Actually, that is what we recommend is needed. We tried, in our report, to provide several examples of where there is inconsistent policy now, and we are recommending that they try to focus and develop criteria that are clear, and that they communicate and they apply those criteria on a consistent basis.

Senator BINGAMAN. All right.

Let me ask Mr. Milligan—and thank you for being here; I am sorry you are still not in New Mexico—you expressed some skepticism about how much savings could be achieved, how much these problems could be corralled, the extent to which they could be corralled.

Do you have thoughts as to whether there are legislative proposals that we ought to be enacting here, or do you see this as something that CMS can do by rule, or exactly where do we come in on this? One thing that is obvious is, we do not have a consensus here in the Congress as to the extent of the problem.

I noticed the House recently struck $80 million out of the Labor HHS appropriation bill for fraud and abuse efforts. The Statement of Administration Policy points out that this is a major problem, as they see it, the decision by the House Appropriations Committee.

What do you think Congress needs to be doing? I would assume you would think that the administration is right, that we at least ought to be providing the funds the administration requests to deal with the problem, but what else?

Mr. MILLIGAN. Thank you, Senator Bingaman. I do want to agree with Mr. Smith, that I think that the recycling of funds can distort the Federal matching rate in a way that is inappropriate.

I am not by any means trying to suggest that that is acceptable, I just am trying to caution folks that the nature of the relationship between the governmental provider and the entity that provides the intergovernmental transfer, whether it is a State health department or county health department, I think that there are so many financial transactions that go back and forth, it is going to be difficult to isolate, in terms of that wire transfer, is it Medicaid funds, is it not Medicaid funds.

So my main suggestion to the Congress and CMS, both, is to do what they think is appropriate to address the recycling issue, and then in a more systematic way, identify what the scale of the problem is nationally. I have not seen the assumptions underlying the President's expected savings in that area, but I think that it is quite likely that it is overstated because of the enforcement difficulty. So, I just think that that merits a little bit more review, first.

Senator BINGAMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bingaman.

Now, Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman.

I do think this is such a critically important issue. Medicaid has been called the "workhorse of the American health care system," and that is exactly what it is, if you look at States like mine, where it is used tremendously in providing the kind of adequate health care that needs to be provided to those who could not get it anywhere else. That is very important.

We also know that fraud and abuse do exist in the Medicaid program. We do not want to shy away from that, but my hope had been that we would not spend all of our time on just Medicaid fraud and abuse, but recognize that there are other areas in health care that weigh into that, maybe a broader conversation about the uninsured and the long-term care, and certainly the growing number of individuals that depend on Medicaid for their health care.

I do not think we can solve this problem without looking at those problems as well, because they are all a part of the overall concern that we have in terms of the cost of health care and the need for it that exists for all of our constituents. So, I hope that we will look at a broader conversation at some point to really bring all of these into perspective.

A couple of questions. Mr. Smith, we have talked about the President's budget and some of the proposals to change that Federal oversight of State financing mechanisms.

The one that is of particular concern to me is the States that utilize the provider tax, which is very much legal and was passed by Congress to help the States raise those Federal dollars. We in Arkansas do use the provider tax on nursing homes. To say that the States already have a tough time funding long-term care is just an understatement, to begin with.

We use those provider taxes for direct patient care. We would lose about $25 million if the President's plan was implemented. What is your justification for eliminating such an important revenue stream, and where do you look to replace that? What are your suggestions to these States of where they can come up with that loss of dollars?

Mr. SMITH. Thank you, Senator. There are two provisions on provider taxes in the President's budget. One we believe is just a loophole that no one intended, and to close that would be appropriate. That is the way managed care organizations are subject to the tax.

What we were seeing is simply a clear cost shift to the Medicaid program. Provider taxes have a long history to them. They are to be uniform, broad-based, and have no hold-harmless provision.

I would say this is an area of growing interest that we see from consultants trying to find ways around those limitations, and we are very concerned. But the upper amount, the 6 percent threshold, is simply an area that we want to bring to the Congress' attention.

We believe that this is an important question, whether Congress wants to determine whether or not the Federal Government wants to match taxes that are made on providers to where, really, there is no State share involved. The provider is paying the tax, the Federal Government is making the match. There is no provision for the State.

Senator LINCOLN. I would just say that Arkansas does not use consultants, so every nickel that we are getting there is going to provide care to people. I would say, I think we have to look seriously at where you are going to make up this difference, because without the consultants, ours is going straight to patient care and it is going to be a tremendous shortfall.

Mr. SMITH. Again, a tax that meets all three parts of the test, we have approved, and we continue to recognize those.

Senator LINCOLN. Right.

Just a follow-up to some of what has already been talked about, Ms. Edwards and Ms. Allen.

Ms. Edwards, in your testimony it states that you have trouble understanding CMS's State financing requirements and whether they are in violation. Your testimony is not the first time I have heard it. We have certainly heard it much.

I have trouble understanding how States can possibly comply with the CMS policies if they do not understand the policies and the requirements. They do not know they are complying with the policies, they are not notified when changes are made to policies that might impact them.

And I guess the concern comes from, also, some of the statistics that come out of your organization's report, Ms. Allen, and that is, if CMS has eight employees assigned to fraud and abuse control activities compared to what we are doing in fraud and abuse in Medicare, it found that CMS's commitment to helping States is enormously limited. They are not investing in oversight. They spend $14 million on Medicaid oversight, and more than $700 million on Medicare oversight.

I mean, is there a problem here in terms of priorities? We know there is a problem that exists and we want to be helpful, but there has to be, I would think, some in-house priorities in terms of how you are going to direct those resources and those priorities of looking for that fraud and abuse, and making some kind of conversation and connection and ability to communicate with these States in order to be able to rectify those problems.

I am gathering that both from your testimony and your report. Are we consistent there?

Ms. EDWARDS. Mr. Chairman, Senator, I would certainly encourage that CMS promulgate rules around the financial requirements. Where they have done that, we have found it very helpful.

It is extremely difficult to plan the program, especially when you are making commitments of billions of dollars a year on into the future if you do not know for sure that the financial arrangements that you are counting on are going to be financial arrangements that hold up. Otherwise, States are making commitments that we may not be able to meet if, in fact, that financing changes midstream.

We have urged promulgation of rules so that there is full public debate and ability for people to provide input, everybody knows the rules, and we can try to plan our programs accordingly. I think that would help all of us.

Frankly, it would also help us deal with the problem of folks who show up and say, we are experts, we know how to do this. It has been done other places, therefore it will be all right. Just do this, it will be great.

Because if we, as State program managers, protest or suggest that perhaps that is not going to be a reasonable way to run the program into the future, we are roundly criticized from many fronts for not doing our best to bring the revenue to the State to support those public programs. So, I really do think we would all benefit from more clarity, in a way that has been done through formal promulgation.

Senator LINCOLN. Mr. Smith, do you have a response to any of those concerns, particularly in terms of priorities and resources being directed towards the fraud and abuse in Medicaid?

Mr. SMITH. Senator, in my opening statement and in some of my responses, I have said that the GAO was looking very narrowly at our performance, and I urge the committee to look at the results of the progress we have made, with the understanding that there are many different partners in this area.

Senator LINCOLN. So do you think there is no problem at CMS? I mean, are there any improvements that you would recommend?

Mr. SMITH. This is an area in which we have made great progress. Certainly, we can always do better, and we are committed to doing that.

Senator LINCOLN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

A question just came to my mind that is not part of the efforts that we have put together to think of questions in advance. That is, for those of you now testifying who had anything to do with consultants, this thought came to my mind.

They give you advice, the State advice, or local government advice on how to tap into the Federal treasury for more Medicaid funds. Are they around if you run into problems with the Federal Government and their plan for you getting money is not appropriate? Are they around to help you argue your point when you get into trouble with the Federal Government and they try to recapture money?

And, more importantly, if you get penalized, do they give up any part of their contingency fee for giving you the wrong advice? Am I asking something that you never thought about? If you have not, then that is all right, too. We will move on.

Ms. EDWARDS. Mr. Chairman, Ohio has not had this kind of a contingency arrangement, but I have certainly talked with some other States and I think, in many cases, the contracts have an end.

Unless provisions were made in that up-front contract for there to be some liability on the part of the consultant giving the advice, then there would be, in most cases, I would think, no payback, though I think a State might also build that into an arrangement if it really wanted to.

I want to be clear, consultants are enormously helpful in very legitimate ways. I think, as Ms. Allen said, we all use them and find them, in many cases, extremely helpful to provide legal advice, concentrated analytical capacity, information about other States and how programs are running.

I do think that there sometimes certainly can be a pretty strong profit motive around some of these arrangements, and I think CMS has been appropriate in discouraging some of those.

The CHAIRMAN. I do not know whether there is any comparability or not, but when we have been having hearings in this committee on tax shelters for corporations, some of us that have been working on that resent the major accounting firms, major law firms, and major investment bankers that think these up, selling them, sometimes, on a contingency basis of the tax that is saved.

Then when an individual corporation has gotten in trouble—and we have had these corporations testify, mostly smaller corporations, but still with a lot of money that can be lost through paying additional taxes, and more importantly, paying the penalties—the people who sell the tax shelters are not around, and you have to defend yourself before the IRS.

It is one thing to have that situation in place to avoid taxes, quite another for a corporation to think up their own interpretation of the Tax Code and decide they only have to pay this amount of taxes, and if they are right, they are right, we do not expect to collect more than the dollars they owe, but if they are wrong, at least they are defending their own decision rather than somebody else thinking up something that turned out to be wrong, and somebody suffering.

It could be somewhat comparable in the sense of these consultants giving advice and the States accepting it and then being wrong, and they are not around any more to help the States through the process, and they have still profitted from it.

In either case, it seems to me that what we need to do is have the States who read the Federal law decide what is appropriate for them, and then make use of the Federal law. I guess I do not have as much sympathy for consultants as you just expressed.

I do not find fault with your having that position, but it seems to me that we have a better relationship on the Federal/State partnership when we have elected or appointed State officials dealing with those Federal officials on a more transparent basis.

I am going to start with Mr. Reeb. Is it possible that if all enhanced payments made to public providers as part of the upper payment limit rules were required to be retained by those providers, the providers would, in effect, have more funds available to spend on patient care? Do you believe that some transfers have actually jeopardized patient care?

Mr. Reeb. Yes, Senator. Our work has shown that, should all the money be retained by the particular facility, the profit that they would make would be 100 percent greater than their total costs.

The present rules allow for upper payment limits to be calculated within a funding pool, and then all the payments can be made to one facility. So the one facility is the State clearinghouse, in effect, for that one day's transaction. All you need in Medicaid is to make an expenditure, and you can bill for Federal participation. The requirement that it stay at the location is where we bring in the cost element that says, at least do not pay them more than that facility's total cost.

We did find, in our four nursing homes that we looked at in three different States, there were over $400 million in upper payment limits made, enhanced payments, and only about 10 percent of that was retained by those four facilities. So, over $350 million was transferred back to the county and State governments.

The Chairman. So then only just a very small amount would be potentially used for greater patient care.

Mr. Reeb. Many times what we find is nothing is retained, sometimes maybe 10 percent.

The Chairman. Mr. Smith, after listening to all the testimony today, it is pretty clear that the oversight of intergovernmental transfers remains a problem. Dr. McClellan discussed IGTs at his confirmation hearing in April of last year.

He said, "As you point out, the issue of governmental transfers is complicated. Much confusion has been created in recent years, due, in part," and this is my emphasis, "to a decrease in Federal oversight of the program."

What effort have you made to improve the oversight of the Medicaid program?

Mr. SMITH. Mr. Chairman, a couple of different things, and they are all key. One, this single team that reviews all the State plan amendments dealing with reimbursement, is a well-trained team that is now in place and doing great work.

Second, we have not gotten to quite all the 100 FTEs that we had set out to. I believe we are up to 97 FTEs. We have recruited some very talented staff to participate in these reviews. These are highly qualified people, in many respects, auditors from the States that have joined the Federal team to provide this oversight.

So I very strongly believe, Mr. Chairman, that since the Administrator's confirmation, we have made great strides to strengthen the oversight of the program.

The CHAIRMAN. Could I ask you to react to Leslie Aronovitz's testimony indicating that staff have not been deployed to address IGTs and have not been adequately trained?

Mr. SMITH. I do not know at what point in time she took her snapshot of the program. But certainly we have staffed up over time, we have done training over time, and we believe such training needs to be done continuously.

But part of what we do is to integrate these individuals with the full team. We have made great improvements, and I would hope that when they look at us again, they will see that improvement as well.

The CHAIRMAN. Ms. Allen, your testimony has pointed out significant problems with the States' uses of intergovernmental transfers and contingency fee consultants contributing to increased financial risk to the Federal Government. What solutions do you think should be considered to overcome that?

Ms. ALLEN. There are several that we would recommend, some to the Congress and some to CMS directly. In terms of the supplemental payments, the recycling of funds, we and CMS are of like mind that probably the thing that could best respond to that issue is to legislate that the Federal share of payments should not exceed that of governmental providers' actual costs.

Beyond that action for Congress, we also have made several recommendations for CMS. Part of that is to try to promulgate its rules on a consistent basis. Again, our report and testimony provide examples of where there is some inconsistency, and Ms. Edwards also has pointed out some of those today. So, we would suggest that CMS take that action as well.

The CHAIRMAN. Mr. Reeb, you have reported that problems exist with payment of therapy services delivered in a school setting. What do you see as the root cause of the problems, and what do you suggest as the solution?

Mr. REEB. What we have seen is that the school districts are not being overseen adequately by the State governments. We pay the funds to the State government or the Medicaid agency, and they have different arrangements with the school districts as to the funding and as to oversight activities that go on.

I think with the State agencies that we reviewed, and we have been in 18 States, it appears as if they do not have a systematic process of reviewing the claims for accuracy.

We have reviewed school services and subsequent claims that are being delivered by the educational units, where there is no guarantee that the service was delivered, nor that the service was delivered by the right person.

And then documentation is the biggest problem. Most States cannot prove to you very well that the services were rendered on the days for which they billed Federal participation.

The CHAIRMAN. Well, this ends our first day of hearings. Obviously, I want to thank you, as witnesses. There are a couple of you that went out of your way that I want to say thank you to. Mr. Reeb, you rescheduled a longstanding vacation to be with us today. I thank you for going that extra mile.

And, Ms. Allen, I have referred to this before, but you and your team at GAO delivered to us a report 1 month earlier than scheduled, and I thank you for that.

Today, we heard about the complexity of the Medicaid program and the paltry resources devoted to overseeing it. Oversight of the Medicaid program is critical to ensure that Medicaid funds are spent on behalf of intended beneficiaries. What we know about fraud, waste, and abuse in the Medicaid program is likely only the tip of an iceberg. I think we can conclude that after today's hearing.

Tomorrow, we will consider more ways that the Medicaid program is short-changed, including efforts to manipulate drug prices and hide assets to qualify for Medicare.

At the conclusion of this hearing, I am going to propose new steps to strengthen oversight of the Medicaid program. We need an improper payment rate for Medicaid, or something similar, to create more accountability in the program.

I am also going to send a letter to the Governors of our 50 States to better understand how States use consultants to maximize Medicaid revenues and to recover third-party liability. We obviously need to get a handle on the impact of consultants on Medicaid.

Thank you all very much. Hearing is recessed.

[Whereupon, at 12:28 p.m., the hearing was recessed, to reconvene at 10 a.m. on Wednesday, June 29, 2005.]

MEDICAID WASTE, FRAUD, AND ABUSE: THREATENING THE HEALTH CARE SAFETY NET

WEDNESDAY, JUNE 29, 2005

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to recess, at 10:08 a.m., in room SH–216, Hart Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Present: Senators Hatch, Snowe, Thomas, Baucus, Bingaman, Kerry, Lincoln, Wyden, and Schumer.

Also present: Emilia DiSanto, Special Counsel to the Chairman, Chief Investigative Counsel.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Good morning, everybody. I thank you for joining us today for Day 2 of a very important hearing. We have witnesses who have flown in from far away, and I thank everybody who had to make a long trip.

Yesterday, we learned about some significant problems with the Medicaid program. At the conclusion of yesterday's hearing, we discussed efforts to correct them and efforts to help reduce the impact that fraud, waste, and abuse are having on the sustainability of a very important health program.

Today, we have two panels again to discuss more problems with fraud, waste, and abuse in Medicaid. Our first panel is here to discuss prescription drug pricing, an issue that has been central to health care policy concerns that has gone on now over the past several years.

Medicaid paid $30 billion for prescription drugs in fiscal year 2004, and the costs of both health care and drugs, as you know, continue to rise.

Prescription drug pricing is a very complex area generally, but even more complex as it affects Medicaid. The various formulas and acronyms alone are enough to confuse anyone.

As recent lawsuits and settlements have shown, drug pricing is an area of Medicaid with significant levels of waste, fraud, and abuse. For example, between 2001 and 2004, the Department of Justice and the States' Attorneys General recovered nearly $2.5 billion from various pharmaceutical companies. This amount includes both Medicare and Medicaid. However, these settlements are evidence of systemic, industry-wide problems that we should be addressing.

The cases and settlements often speak for themselves: Pfizer, $430 million; Schering-Plough, $345 million; TAP Pharmaceutical, $875 million, and you can go on with the list. Most of these settlements resulted from cases filed under the False Claims Act of the Federal Government.

As the principal author of the 1986 amendments to the False Claims Act, I have worked to ensure that its provisions are faithfully enforced. Whistle-blowers frequently risk everything when bringing false claim cases. I am pleased that our first witness of the day is a brave woman who will discuss her experiences as a whistle-blower.

Our whistle-blower will be followed by testimony from the Department of Justice and Office of Inspector General. We will hear testimony on Federal oversight of the Medicaid drug pricing program, including drug pricing fraud and drug company settlements. The OIG will present its recent work, which will show potential for significant savings in the Medicaid program.

The drug pricing panel will also include a representative from the Texas Attorney General's Office, who will provide a State perspective on problems with the prescription drug pricing.

Finally, we have a representative from the Pharmaceutical Research and Manufacturers of America, PhRMA, for short, who is here to discuss the industry's perspective on drug pricing.

Our second panel will address another troubling trend in Medicaid, transferring assets to quality for Title 19, particularly nursing homes. Six witnesses today will discuss these asset transfers, including testimony from a long-term care facility representative, and residents of that facility.

In addition, we have CRS providing background research on asset transfers and Medicaid estate planning and recovery; a representative from the Oregon Department of Human Services testifying about estate recovery efforts in Oregon; and we will also hear from the long-term industry, specifically a representative from MetLife being here, a member of the American Council of Life Insurers. Finally, we will hear from the dean of the Public Policy Institute at Georgetown University.

Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. I appreciate you holding this hearing. Clearly, we have to get a better handle on Medicaid. Medicaid drug spending is growing fast, for several reasons. One, partly because Medicaid covers more people than it used to, and partly because, as the OIG will describe in his testimony, Medicaid pays too much for drugs. It also makes some other mistakes.

Medicaid uses a system called Federal Upper Limit to encourage the use of lower-cost generic drugs. But for this system to work, CMS must add drugs to the Upper Payment List in a timely manner, and CMS has not done that.

The OIG report says that if CMS had added just 55 of 90 eligible drugs to the list, Medicaid could have saved over $120 million in 2001. As of 2004, CMS has only added 25 of 109 eligible drugs. Clearly, CMS is not doing its job.

The second half of this hearing focuses on long-term care. We will hear how clever estate planners help some wealthy people transfer their assets to qualify for Medicaid and the long-term care that Medicaid covers. That contravenes the intent of Medicaid and, clearly, must be changed.

A third of the elderly are likely to transfer their assets. It is true that the average amount may be only as high as $5,000. Nevertheless, it is wrong. It is up to us, it is our obligation, Mr. Chairman, to make those changes.

I might add, just to keep this in perspective, that the Kaiser Family Foundation, today, released a new survey that demonstrated that Americans overwhelmingly support the Medicaid program and oppose budget cuts.

Three out of four Americans think that Medicaid is very important, and rank it the third most important program after Social Security and Medicare. Half of Americans support putting more Federal money into Medicaid—not a lot of surprise there—and 44 percent support maintaining current spending.

Six in ten Americans think Medicaid is in financial crisis. Although they think that, there is no majority of support for any of the key proposals being considered for reform. I think those are referring primarily to the Governors' proposals and not to some of the suggestions that we will hear today.

This all says to me that we had better be careful here. We should look before we leap, and take all this testimony with a couple grains of salt, but then fulfill our obligation of plowing ahead and just doing what is right. Clearly, there are a lot of things we need to do to make Medicaid work a lot better.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

I will now introduce our panel. Beatrice Manning will testify about her extensive inside knowledge of organization and operation of a major scam against Medicaid perpetrated by the company she worked for, IGT, Inc., a subsidiary of Schering-Plough.

Ms. Manning is here today to provide testimony regarding fraud she uncovered, and the subsequent losses the scam caused the Medicaid program. So, I thank you for testifying.

Then we will go from her to Timothy Coleman, Senior Counsel to the Deputy Attorney General, U.S. Department of Justice. Mr. Coleman will testify about litigation filed by the Department of Justice against the pharmaceutical industry as a result of prescription drug pricing violations. Mr. Coleman will provide insight into the scope of the problem and the settlements that have been entered into.

Our third witness, Robert Vito, is the Regional Inspector General for Evaluations and Inspections for the Office of Inspector General, Department of Health and Human Services, and is testifying to some of the fraudulent practices found regarding prescription drug pricing in Medicaid. In addition, Mr. Vito will provide three new reports showing that Medicaid, in fact, pays too much for prescription drugs and that a change in pricing structure would result in significant savings to the program. You worked extra long to make those available to us, Mr. Vito, so we thank you for the extra time you and your staff put in on that point.

Our fourth witness on this panel, Patrick O'Connell, Assistant Attorney General in the Attorney General's Office in the State of Texas, is testifying about prescription drug fraud in the Medicaid program from the perspective of States, his, primarily. Mr. O'Connell will discuss lawsuits that have been filed by his office, in addition to settlements that they have obtained from suits against the industry. He will also discuss up and coming areas of fraud, including third-party liability.

Our last witness, Marjorie E. Powell, is Senior Assistant General Counsel with the Pharmaceutical Research Manufacturers of America. Ms. Powell is here today representing the pharmaceutical industry.

I would thank all of you. I am going to start out with Ms. Manning.

STATEMENT OF BEATRICE MANNING, *QUI TAM* RELATOR

Ms. MANNING. Good morning, Senators. I am Beatrice Manning, one of the whistle-blowers in the recent government settlement with Schering-Plough resulting in a $50-million criminal fine and a $292-million civil penalty.

I worked at Schering-Plough for slightly over 5 years. During the final 4 years of my employment, I was an active whistle-blower.

I came to Schering-Plough after having been in academia and having had a 10-year career in public health. While at Schering-Plough, I was the manager of Opportunity Identification at a wholly owned subsidiary, Integrated Therapeutics Group, or ITG. Now I am a student at Andover-Newton Theological School.

Schering-Plough used an intricate scheme to cheat Medicaid out of hundreds of millions of dollars. It evaded its responsibility to charge the U.S. Government and its beneficiaries the lowest price it charged the private sector, that is, the best price as required by Federal law.

Most of the scheme was carried out using the subsidiary, ITG, which in retrospect, I believe, was created specifically to commit fraud. The scheme, which centered on Schering's blockbuster drug Claritin, had three major prongs that served as what I will call kickbacks in disguise.

These kickbacks resulted in Claritin actually costing many insurers and HMOs an equal amount, or less, compared to Allegra, its major competitor. This lower amount, however, was not reflected in Schering's calculation of best price.

The first prong. The subsidiary provided free or well-below-cost health management services to HMOs that put Claritin on formulary. These services were not provided to Medicaid clients, and I would add, including Medicaid clients enrolled in those same HMOs.

The value of these services was not included in the best-price calculation. ITG would sign a contract with the HMO, and this contract would be totally separate from the cash rebate contracts Schering-Plough itself would sign with insurers.

Medicaid auditors would review the rebate contracts with Schering-Plough, not the subsidiary ITG, and thus would never see the additional kickbacks. I invite your attention to Exhibit A of my testimony, which is a draft memo from Linda Zhou, who was then head of Schering's Contract and Pricing Division.

On page 3, under I, she states, "ITG's services complement and enhance Schering's pharmaceutical products and meaningfully differentiate them from the competition. Thus, they provide our primary means of implementing the strategy to *compete on a basis other than price.*"

On the next page of that same exhibit under the section, "Increased Profitability," she indicates that this has allowed Schering to decrease its discounts, by which the best price is determined, from 23 percent to 17 percent, and right above we see that Schering, as early as 1998, was increasing its sales, net of rebates, by over $50 million per year as a result of these health management contracts.

Also note that, throughout this memo, there is no indication that health plans are paying anything for these health management services. The return on investment is calculated in Table 2 by dividing the increased sales of Schering drugs by ITG's operating expenses, showing a nearly 4:1 return on investment for Schering.

In essence, ITG's health management services to for-profit HMOs and other health insurers was being financed by the higher prices Medicaid was paying for Claritin.

I invite your attention to Exhibit B, showing the relationship between ITG and Schering-Plough. Note that Roch Doliveux is both the CEO of ITG and the senior vice-president of Managed Care within the Schering organization. He reports directly to Raul Cesan, who was then the CEO of Schering Laboratories. The subsidiary, ITG, was tied to Schering as the highest levels.

Beyond the health management services, ITG also used what it called "partnership fees" in its relationships with pharmaceutical benefit managers, or PBMs, which are often used by HMOs and other insurers to manage the pharmacy benefits part of coverage packages.

ITG would engage PBMs to conduct analyses for developing pharmacy metrics to be used in treating respiratory patients. There would be analyses that Schering already knew the outcome of. For example, better treatment of allergies leads to fewer office visits for upper respiratory infections.

I want to be specific here. These analyses were real and the results were real, and I believe that they indicated appropriate treatment for patients. However, partnership fees to do such studies were well above their actual costs.

As the fees increased over time above cost compared to what I would pay a consulting firm, I and others were asked by management to indicate that the fees were appropriately reflected effort and value to ITG. When I and others refused, we were counseled by our bosses and questioned concerning our loyalty to the company.

I invite you to examine Exhibit C, which is an internal document showing Schering-Plough's flow of pharmaceuticals and cash. Two points are important if you look at the bottom of this chart: "Schering-Plough provides the HMO with free or underpriced services," *i.e.*, health management, and flowing from that same box, up and to the right, you see "Rebate check and partnership fees to PBMs."

ITG was used for both of these activities, and these rebates in disguise would not show up on the books that Medicaid audited in Schering itself.

Finally, Schering used a law designed to allow pharmaceutical companies to give drugs free or at nominal costs to entities such as public hospitals or inner city and rural health clinics serving low-income populations, without these gifts entering into best-price calculation.

Schering, however, used this provision to give nominally priced drugs which were off patent, and therefore less profitable to Schering-Plough, to equalize the difference in price between Claritin and Allegra.

The last page of Exhibit D shows an exact example of this calculation where these nominally priced drugs are used to make up the difference in price, which I think was almost $10 million.

This scheme, and others like it, continued so long without detection because work was organized to make it quite difficult for any one person to put together the entire scheme, unless one was working at the very top levels of the company.

The Medicaid Pricing Unit was located in an entirely different location, had no contact with ITG, and would not have seen ITG contracts. Even within ITG itself, work was intentionally siloed so you were not sure what your colleagues were doing.

Second, I want to stress that this scheme did not result from public corruption or inadequate Medicaid auditing. In essence, Schering was keeping two sets of books.

Third, HMOs were not innocent participants in this scheme. Some of the best-rated HMOs, such as Harvard, Tufts, and Kaiser would not accept health management services as a trade for putting Claritin on formulary. Those honest HMOs were disadvantaged by this scheme, having to either develop their own or purchase health management programs.

Fourth, when the investigation got hot, there were serious internal attempts within Schering to force blame down. Two or 3 years into the investigation, we started getting "compliance" training and surveys and tests.

Interestingly, none of the training or questionnaires addressed best price, the major violation. The corporate culture was designed to encourage individuals not to question actions.

Examples for myself include "counseling" sessions with my boss, where I would be told things like, your job is not to point out the problem. Your job is to come up with solutions.

Finally, I believe there is still a considerable lack of information regarding *qui tam* and how to file *qui tam* complaints. We heard about this mechanism when we consulted our lawyer, Neil Mullin, whom we had engaged because we were being retaliated against for signing with a secretary who had reported being sexually harassed. Had it not been for Neil's knowledge of *qui tam* and his willingness to take on this case, it probably would not have ever been filed.

Despite the successful outcome of our case, I do have some regrets which I think have policy implications. No one was ever held criminally responsible in a personal way for their actions. No executives were pursued.

While our settlement was one of the largest Medicaid settlements ever, to some extent the $350 million plus legal expenses was the cost of doing business for Schering-Plough.

While Claritin was still on patent, there were several years when Schering collected revenue over $2 billion per year from Claritin sales. To be a more serious deterrent, *qui tam* must result in higher settlements and executives themselves must be held personally responsible.

Finally, I want to stress the important of *qui tam* in decreasing fraud. The intricate bookkeeping, siloed work environment, and use of subsidiaries have made it virtually impossible to catch fraud by auditing alone.

I also think that government needs to consider more extreme administrative controls in dealing with drug companies, such as fee schedules similar to those used in relation to doctors and hospitals. This industry has become arrogant and amoral in regard to its dealings with government, and patients, for that matter.

Thank you for inviting me to share my experience with you.

The CHAIRMAN. Just speaking generally about whistle-blowers, I have said we could not do our Congressional job of oversight without patriotic people like you.

Ms. MANNING. Thank you.

The CHAIRMAN. We thank you for your work, because we need every encouragement we can to make sure that people live by the rules, and you give us that encouragement.

[The prepared statement of Ms. Manning appears in the appendix.]

Mr. Coleman?

STATEMENT OF TIMOTHY COLEMAN, ASSOCIATE DEPUTY ATTORNEY GENERAL, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, DC

Mr. COLEMAN. Thank you, Mr. Chairman. Good morning, Mr. Chairman and members of the committee. Thank you for the opportunity to be here to represent the Department of Justice in this important hearing.

Mr. Chairman, the Department of Justice is fighting a multifront war against health care fraud. We have investigated and taken action against a large number of individuals and organizations for a wide range of health care fraud schemes, and we have done that with help from our Federal and State partners, like the Office of the Inspector General, like the State Attorney General's Offices, and we have done that with help from people like Ms. Manning, who play the role of private attorneys general, to use the parlance of the False Claims Act.

Of all the misconduct that we at the Department of Justice have seen in our investigation, the activity that has perhaps caused the greatest harm to the Medicaid program involves fraud, waste, and abuse in connection with the sale of prescription drugs and other pharmaceutical products that are paid for by Medicaid.

Now, let me emphasize at the outset that most pharmaceutical companies and the people that work for them are honest and hard-working people. In fact, the pharmaceutical industry has made historic strides in treating diseases and saving lives. But a few bad apples have threatened to tarnish the reputation of the entire industry.

In the course of our investigations, we have uncovered several types of schemes that have been used to defraud Medicaid by manipulating the prices of pharmaceutical products, and I will briefly summarize three of them.

One common scheme is known as "marketing the spread," and it is just as nefarious as it sounds. In this scheme, the manufacturer inflates its reported price for the pharmaceutical product, which is used by the States to set the amount that Medicaid will reimburse. Then the manufacturer sells that same product to the customer at a price far below what was reported, creating a "spread" between the price the customer pays and the amount that the customer can bill Medicaid. The seller then touts that spread, which is pure profit for the customer, in order to induce sales and increase its market share.

In a second type of scheme, the manufacturer misrepresents the best price that it charges for a product, which determines the amount the manufacturer is required to repay to the States under the Medicaid rebate statute. This type of scheme can involve fraudulent private labeling of products to avoid the best-price reporting obligations. It can involve kickbacks, which also violate the anti-kickback statute, and it can involve other types of discounted arrangements that affect the best-price determination.

A third type of scheme involves illegal marketing of pharmaceutical products for uses that are not approved by the Food and Drug Administration. Once the FDA approves a drug, a doctor can prescribe it for any medical use that he deems appropriate in the exercise of his medical judgment. But so-called off-label promotion by the manufacturer can cause Medicaid to pay for drugs that are not eligible for reimbursement.

Now, what has the Department of Justice done about these schemes? We have conducted a series of major, long-term investigations of pharmaceutical manufacturers over the past few years, and I see that some of them are listed on the video monitors that the audience and the panel can see. Mr. Chairman, you mentioned a number of the major cases in your opening remarks.

Now, some of these cases have been settled, like the ones represented here, and others are still ongoing. Some other examples of cases that we have done in the past few years are included in my written remarks, which I will respectfully refer you to.

In the cases that have been resolved in the past 6 years, we have recovered more than $2 billion in losses to Federal and State programs, including Medicaid. In several cases, we have brought criminal charges and obtained substantial fines against the defendants. In appropriate cases, criminal prosecution helps to ensure that those involved in misconduct will not regard law enforcement responses to Medicaid as simply a cost of doing business.

We regard these cases as a major success. The Department's attorneys, FBI agents, and other professionals around the country have worked tirelessly to protect the integrity of the Medicaid and Medicare programs.

We could not have achieved that success alone. Many of these cases have been initiated by *qui tam* relators like Ms. Manning under the False Claims Act. As you know, Mr. Chairman, as one of the principal sponsors, as the principal author, the False Claims Act has been an essential tool for detecting fraud, waste, and abuse in the health care field, and in so many other fields.

We have worked closely with the State Attorney General's offices, the Medicaid Fraud Control Units, and other State authorities to recover substantial amounts for State Medicaid programs.

As in other areas of health care fraud enforcement, we have investigated pharmaceutical schemes in very close partnership with the Office of Inspector General for the Department of Health and Human Services. We also coordinate regularly with the Centers for Medicare and Medicaid Services.

What should Congress do about Medicaid fraud, and particularly about fraudulent schemes involving Medicaid reimbursement for pharmaceuticals? Our investigations, as I have tried to summarize today, have shown that the prices used to determine Medicaid reimbursements and rebates are subject to manipulation.

We urge Congress to adopt the proposals set forth in the President's budget to reform the pricing system related to Medicaid. Specifically, the President has proposed to require that State Medicaid programs use the average sales price, which is defined by statute, to determine reimbursements to pharmacies. The President has also proposed replacing best price in the Medicaid drug rebate formula with a flat rebate.

We are prosecutors, Mr. Chairman, and I will defer to our regulatory partners on the details of other legislation and other regulatory measures that would best help reduce fraud, waste, and abuse. Thank you again. We applaud this committee for its leadership on this important issue.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Coleman appears in the appendix.]

The CHAIRMAN. Now, Mr. Vito?

STATEMENT OF ROBERT VITO, REGIONAL INSPECTOR GENERAL FOR EVALUATIONS AND INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, PHILADELPHIA, PA

Mr. VITO. Good morning, Mr. Chairman and members of the committee. I am Robert Vito, Regional Inspector General for the Office of Evaluation and Inspection within the Department of Health and Human Services' Office of Inspector General.

I am pleased to appear before you today regarding Medicare/Medicaid drug pricing issues. My testimony will present the results of three new OIG reports, which we will release today. I will also briefly discuss problems Medicaid faces in recovering pharmacy payments from third parties.

My written testimony contains additional information about the OIG's body of work related to Medicaid drug pricing. It also highlights the efforts by the OIG and its partners to identify and pursue fraud and abuse in Medicaid.

Years of work can be summarized in one sentence: Medicaid pays too much for prescription drugs because the program relies on published prices that do not accurately reflect pharmacy acquisition costs.

While States must reasonably reimburse pharmacies for prescription drugs, they often lack access to accurate pricing data necessary to do so. Because of this, States rely on published prices, like average wholesale price, AWP, and wholesale acquisition costs, WAC, when determining Medicaid reimbursement.

Unlike States, CMS has access to accurate pricing data. CMS collects average manufacturer prices, AMP, for Medicaid-covered drugs, and average sales prices, ASP, for Medicare-covered drugs. Both are statutorily defined prices based on actual sales.

The two companion reports we will release today compare these statutorily defined prices, AMP and ASP, to prices published in national compendium, AWP and WAC. Overall, we found that the statutorily defined prices based on actual sales are substantially lower than the published prices.

The sales-based prices are also considerably lower than the States' estimates of pharmacy acquisition costs based on AWP and WAC. We found, overall, AMP is 59 percent lower than AWP at the median. In contrast, the median State estimated acquisition cost formula is AWP minus 12 percent.

The difference between AMP and AWP is greatest for generic drugs. Among generics, AMP is 70 percent lower than AWP at the median. In contrast, AMP is 23 percent lower than AWP for single-source brands, and 28 percent lower than AWP for multiple-source brands at the median.

Comparing ASP to AWP reveals a similar pattern: for generic drugs, ASP is 68 percent lower than AWP at the median. In contrast, ASP is 26 percent lower than AWP for single-source brands, and 30 percent lower than AWP for multiple-source brands.

The disparities between sales-based and published prices for generic drugs have an especially large effect on the Medicaid Federal Upper Limit program. Congress created the Federal Upper Limit program to help Medicaid benefit from lower market prices for generic drugs. Regulations set the Federal Upper Limit amounts at 150 percent of the lowest published price, which is AWP, WAC, or direct price.

To be effective, the Federal Upper Limit must meet two conditions: qualified drugs must be added in a timely manner, and the prices used to determine the Federal Upper Limits must accurately approximate pharmacy acquisition costs.

Previous OIG work focused on the first condition, identifying hundreds of millions of dollars in missed savings. Today, we are releasing a report that addresses the second condition by comparing the Federal Upper Limit amounts to the average manufacturer price.

Overall, we found that the Federal Upper Limit amounts were 5 times higher than the average AMP for generic drugs on the Federal Upper Limit. Compared to the minimum generic AMP, Federal Upper Limit amounts were, on the average, 22 times higher.

We estimate that Medicaid could have saved $161 million in the third quarter of 2004 if reimbursement was based on 150 percent of the average AMP rather than 150 percent of the lowest published price. If reimbursement was set at 150 percent of the minimum reported AMP, Medicaid could have saved $300 million during the same period.

I will touch, briefly, on another area of concern, Medicaid's difficulty in recovering pharmacy payments for liable third parties. Millions of Medicaid beneficiaries have additional health insurance through third-party sources, such as Medicare and private health plans.

Because Medicaid is, by law, the payor of last resort, these third parties are often liable for prescription drug claims submitted to Medicaid. Previous OIG work revealed that hundreds of millions of dollars are at risk when Medicaid is unable to recoup owed money from these third parties.

In conclusion, nearly a decade of OIG work on Medicaid drug pricing leads to one conclusion: Medicaid pays too much for prescription drugs. Simply put, the prices States use to estimate acquisition costs are substantially higher than the prices retail pharmacies pay for drugs.

Not long ago, Medicare faced similar issues. OIG consistently recommended that providers be reimbursed fairly and accurately for both prescription drugs and any associated services. Recently, Congress changed the basis of Medicare drug reimbursement from AWP to ASP. Similar pricing reforms could significantly reduce Medicaid drug expenditures.

Mr. Chairman, this concludes my testimony, and I welcome any questions you may have.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Vito appears in the appendix.]

Senator KERRY. Mr. Chairman?

The CHAIRMAN. Yes?

Senator KERRY. I wanted to thank Ms. Manning very much, a resident of Massachusetts. I want to thank you for your courage. The Chairman already has done that, but we are very appreciative to you.

It is not easy being a whistle-blower and living in that atmosphere, but it is a patriotic act, and you have helped save a lot of money, and helped point the way for us to be able to do a better job.

Ms. MANNING. Thank you.

Senator KERRY. So, we thank you very, very much.

We thank all the witnesses for some very thoughtful ideas about how we can be more effective in this program. I thought, particularly important, however, was your comment—I walked in as you were saying it—that it was not a matter of public corruption, it was a matter of management.

There are many ways in which private sector entities are taking great lengths to be able to defraud, so I think how we approach this is really important, and I thank you, Mr. Chairman, for undertaking it.

The CHAIRMAN. Mr. O'Connell?

STATEMENT OF PATRICK O'CONNELL, ASSISTANT ATTORNEY GENERAL, OFFICE OF THE ATTORNEY GENERAL, STATE OF TEXAS, AUSTIN, TX

Mr. O'CONNELL. Mr. Chairman and members of the committee, good morning. My name is Patrick O'Connell. I am an Assistant Attorney General and Chief of the Civil Medicaid Fraud Section of the Texas Attorney General's Office.

You are obviously familiar with the Federal False Claims Act, which has been providing redress for the United States for fraud since the Civil War. Texas adopted its own version of the False Claims Act in 1995. It is limited to recovery for fraud against the Texas Medicaid program.

In 1999, in response to concerns about growing claims of fraud and abuse, then-Texas Attorney General, now your colleague Senator John Cornyn, created a special civil Medicaid Fraud Section within the AG's office. I have had the privilege of heading up that section since its inception.

When the section was formed, our plan was to aggressively pursue all types of fraud against the Medicaid program. We have investigated and pursued claims against doctors, hospitals, and other providers, which involved typical claims of false billing, false cost reporting, and over-billing.

However, the overwhelming majority of our time and efforts have been concentrated on drug manufacturers. Did we target or place special emphasis on drug manufacturers on purpose? No.

The fact is, whistle-blowers like Ms. Manning brought us cases which showed significant fraud in amounts which dwarfed the cases against our other providers. Because of the limited number of staff and resources we can bring to any one case, we have chosen to pursue those cases which provide the greatest return to the Medicaid program.

To date, we have sued six drug manufacturers in pricing cases brought to us by a relator, Ven-A-Care of the Florida Keys, Inc., a small pharmacy in Key West, Florida.

As you know, State Medicaid programs are required by Federal law to pay pharmacists for prescriptions filled for Medicaid beneficiaries an amount equal to the program's best estimate of the pharmacist's acquisition costs, plus a reasonable dispensing fee.

Ven-A-Care brought us information showing that certain drug manufacturers violated Texas law by intentionally reporting prices to the Texas Medicaid program that did not bear a reasonable relationship to the prices for their products that were generally and currently available in the marketplace.

Unlike most other States which drive pricing information from third party pricing reporting services like First Data Bank, since the 1980s, Texas has required manufacturers who want their products to be eligible for Medicaid reimbursement to fill out a questionnaire for each drug they wish placed on the Medicaid formulary.

For each drug, the manufacturer must report its prices to various classes of trade: its AWP, the price it sells to wholesalers and/or distributors, its direct prices to pharmacies if it so chooses to sell directly, its prices to chain warehouses. Much more information than just the average manufacturer's price.

A drug company representative is required to sign the form and certify that the information in it is accurate and updated within 15 days of any price change.

When Texas relies upon an inflated price report in calculating a provider's estimated acquisition cost, the resulting reimbursement to providers is well above the providers' actual acquisition cost, thus, as Mr. Coleman said, providing pharmacies with windfall profits.

Under the Texas statute, we have broad powers to compel document production and testimony of potential witnesses. In 1999 and 2000, we used these civil investigative demand powers to require manufacturers to produce documents. We also took the examinations, under oath, of several industry representatives.

Based on the information that we received from Ven-A-Care, as well as the information we received pursuant to the CID process, Attorney General Cornyn authorized us to intervene against three defendants in September of 2000: Warrick Pharmaceutical, a subsidiary of Schering-Plough; Dey Laboratories, a subsidiary of Merck; and Roxane Laboratories, a subsidiary of Beringer Engleheim.

The Texas lawsuit was the first State intervention in a *qui tam* case involving pharmaceutical manufacturer pricing fraud. These three manufacturers competed with one another in the market for certain generic inhalant medicines that are typically prescribed for diseases like asthma.

The defendant drug companies are all very ably defended by first-rate, nationally prominent counsel. They spared no expense or effort to defend themselves against our allegations.

In the 5 years from the State's intervention, the litigants have taken approximately 120 videotaped depositions and have exchanged literally hundreds of thousands of pages of documents.

Over the same time period, the State and the Relator devoted tens of thousands of man-hours to the litigation, incurring millions of dollars of costs and attorneys' fees.

In June, 2003, we settled our case with Dey for $18.5 million. In that settlement, we recovered 2.5 times the actual damages to the Medicaid program, as well as all of our costs and attorneys' fees.

In May, 2004, our case against Warrick and Schering settled for $27 million. Again, Texas recovered more than 2 times the actual damages to the Medicaid program.

It is important to remember that these were Texas State settlements only. They did recover the Federal share, as well as the Texas share, but Texas is only 7 to 8 percent of the national Medicaid budget. We continue to provide assistance to authorities in other jurisdictions who are pursuing these, and other, companies.

My time is about up. Mr. Chairman, let me say that new cases are being filed in our office virtually every week. We currently are investigating allegations of the kinds of fraud that Mr. Coleman indicated to you were out there, and we now have cases amounting to more than 125 in our office.

I would like to make clear, in closing, that while Texas is pleased to have recovered these significant sums of money in these *qui tam* cases, litigation is not the most effective way to run this system.

Our Medicaid program and our Attorney General's Office have been required to spend thousands of man-hours responding to discovery requests, preparing for and attending depositions in our litigation.

The program could have used our hard-earned tax dollars to provide more and better services if our personnel were not tied up in litigation caused by manufacturers who gamed the system.

Our current Texas Attorney General, Greg Abbott, has committed the resources of the agency to our efforts to fight Medicaid fraud in Texas. Through this leadership and vision, we have obtained the funding to increase our staffing to eight lawyers—just eight lawyers—plus support staff.

Even with the additional staffing we have obtained, we simply cannot pursue every participant in the system that we find to have engaged in fraudulent activity. We simply do not have the manpower.

For this reason, we are hopeful that Congress will continue to support the efforts of our partners at the Department of Justice. In our opinion, it is also vitally important that Congress maintain the strength and integrity of the Federal False Claims Act. We would not have been able to obtain the successes that we have had without strong law and without the participation of the relators who had the courage to come forward.

Thank you for attention, and I am happy to answer any questions.

The CHAIRMAN. Thank you, Mr. O'Connell.

[The prepared statement of Mr. O'Connell appears in the appendix.]

The CHAIRMAN. Now, Ms. Powell?

STATEMENT OF MARJORIE E. POWELL, SENIOR ASSISTANT GENERAL COUNSEL, PHARMACEUTICAL RESEARCH MANUFACTURERS OF AMERICA (PhRMA), WASHINGTON, DC

Ms. POWELL. Thank you, Mr. Chairman and members of the committee. My name is Marjorie Powell. I am the Senior Assistant General Counsel of the Pharmaceutical Research and Manufacturers of America, or PhRMA.

We are the trade association for the industry that is developing, getting FDA approval for, and bringing to market the new and innovative medicines that are improving the lives of Medicaid and Medicare patients, as well as many of the rest of us.

I would like to note, for example, that the industry, both bio and the pharmaceutical industry, have over 146 new medicines in development for heart disease and stroke, which are two of the major conditions that affect Medicaid patients. Yet, the payments within Medicaid for the innovative prescription drugs amount to less than 7 cents out of every dollar.

We do appreciate the committee's work, both in the Medicaid fraud and abuse area, and Medicare, and throughout the variety of issues that you address, and we appreciate the contributions of this 2-day hearing and the opportunity to testify.

We have been asked to comment, particularly, on the OIG draft guidance and final guidance and the process by which they developed that guidance, and on a number of related issues.

Let me note that PhRMA, as a trade association, does focus on advocacy and public policy issues. Our comments to the OIG's draft guidance focused on a number of policy issues. Because of antitrust issues, we tend not to focus on our members' marketing activities or their pricing decisions unless those issues come up in a public policy context, such as the draft guidance that the OIG proposed, and now the final guidance.

During the comments on the draft guidance, we focused on the need for clarity in the kinds of things that manufacturers would be expected to do in documenting and reporting prices and other expenditures within the Medicaid program.

We continue to believe that it is most effective if manufacturers know ahead of time what it is they are expected to maintain as records, what kinds of things they would report, and how they should report those.

As part of our focus on policy issues, we have also developed a code of interactions with health care professionals. That code was developed initially back, I believe, in the 1980s, was revised in the 1990s, and revised again in 2002.

It attempts to provide some guidance to manufacturers on ways that they should interact with, most typically, physicians and other prescribers, but they are obviously interacting now with HMOs and pharmacy benefit managers, and a variety of other entities within the health care provision system.

We were pleased to note that the OIG, in their final guidance, recognized the value of the PhRMA code on interactions with health care providers. We have not taken a position on the final guidance, except to note to our members that it is available and that they will, of course, be considering that as well as the PhRMA code, and a variety of other things as they put together their own programs.

But we look forward to working with the committee as you move forward after this hearing, and any particular things that you would propose.

Let me stop, because I see that my time is about to run out, and say that I will be happy to answer any questions as well. Thank you.

[The prepared statement of Ms. Powell appears in the appendix.]

The CHAIRMAN. Yes. I have been requested to have two rounds of questioning, and I will be glad to do that. I would ask, then, that members keep within the 5 minutes, and I will try to set a good example, so we can go those two rounds that people requested.

I am going to start with Mr. Vito. Under Federal law, AMPs are required to be kept confidential. If Congress changed the law so AMPs are provided to the States to use for Medicare drug payments, would this price transparency reduce the abuse of the system that we see with the AWP today?

Mr. VITO. Yes. I believe that the AWP system has numerous flaws, because it is not statutorily or regulatorily defined as to the definition of it, and the way it is calculated. AWP is not averaged. It is not a wholesale price. It is not able to be audited or verified.

If you move to prices that are based in statute and regulation, defined by law, then you will be able to audit them and verify them. Both ASP and AMP have those characteristics.

In addition to that, there are characteristics that, if the information is falsely reported, then the government can take action against that. So, any time that you have prices that more accurately reflect what the pharmacies are paying for the drugs and are defined in the statute in regulation and law, it is likely to be better than the AWP system.

The CHAIRMAN. And as a follow-up to that, I wanted to ask Ms. Powell, what is PhRMA's view on replacing AWP with something that is less subject to abuse?

Ms. POWELL. Well, AWP, as Mr. Vito said, is a mechanism that States have chosen to use. In fact, not all States use AWP for all of their reimbursement to pharmacies. A number of States are at least considering moving to other options for reimbursing pharmacies.

But PhRMA has not actually taken a position yet on what might be the most appropriate process. Our focus has been on a variety of other issues. We would be happy to work with the committee as you work through those kinds of issues, but we do not yet have a policy position on what would be the best option.

The CHAIRMAN. All right. And we would welcome your response to our staff if they contact you on that point.

Mr. Vito, it is my understanding that the State of Texas is one of the lead litigants in a case that just came out of seal from Federal Court in San Antonio. The case alleges fraud to a Medicaid program resulting from third-party liability.

Now, I fully understand that you cannot speak regarding specific, ongoing matters in litigation. So I was wondering if, at the least, you could, based on this case, tell us whether you believe there is a change in Federal law that would help prevent the losses to Medicaid that exist because of third-party payors.

Mr. VITO. The OIG had issued two reports involving third-party liability payments. We found that 32 States were at risk of losing over $367 million because they tried to recover from third parties using pay-and-chase.

We also found that almost three-quarters of the State's reported third parties refused to process or pay Medicaid pharmacy claims, and that more States had problems with pharmacy benefit managers, PBMs, than with any other third party.

We had made recommendations, in the reports, that CMS determine whether legislation was necessary to explicitly include PBMs in the definition of third party, as well as to require third parties to match eligibility files with Medicaid, and to allow up to 3 years to recover payments from liable third parties. So, we had made those recommendations. I believe the Texas Attorney General has a case involving that now.

The CHAIRMAN. All right.

Ms. Powell, PhRMA is on record saying that the deck is stacked—and I presume those are the words that somebody in your organization used—against drug companies in the False Claims Act litigation. Today, some organizations are actively seeking reforms that would weaken the False Claims Act.

Could you assure me that PhRMA, on its own or on behalf of its member drug companies, is not funding, supporting, or in any way involved in a campaign to reform or change the False Claims Act?

If you could not answer specifically today, I would request PhRMA to respond for the record, in writing.

Ms. POWELL. Yes, Mr. Chairman. I would be happy to go back and confirm and respond in writing. But let me give you just a little bit of statement. I do not know whether the "deck is stacked" quote was one from me or from somebody else at PhRMA, but the concern with the False Claims Act exclusion provision is that if a manufacturer, who perhaps has 20 drugs on the market, is found to have violated the False Claims Act and is excluded from Medicaid and all health care programs that have Federal Government funding, that imposes an enormous burden on patients who are taking those medications who then are suddenly not able to get all of those medications of that manufacturer.

It seems that, in that sense, the penalty, imposing a burden not only on the company but on the patients who are taking that company's drugs, may be inappropriate for the offense. I am unaware of whether PhRMA is doing anything related to the False Claims Act. I do not believe we are, but I would be happy to go back and confirm that.

The CHAIRMAN. Please do that. The reason I ask that is, over the 20 years of the False Claims Act, originally we got it passed because we needed a tool against the defense industry. The defense industry tried to gut it. Then, pretty soon, they could not succeed, so then they got the American Hospital Association to go out front and cover for them.

Just make sure that you are not used by some other organization, or make sure that you do not use some other organization for cover to get the job done, because we do not want to weaken this legislation.

Ms. POWELL. In the interests of full disclosure, let me say that we have proposed, in our comments on the OIG's proposal back in, I believe, 1997, to exclude indirect providers, we did point out that that imposes an enormous burden on patients.

We did, this year in the State of Texas, urge that, as they amended their False Claims Act, they provide an option for the commissioner of their Health Department to provide an exception when an exclusion would risk patients' health.

The CHAIRMAN. Just in case my colleagues saw that the red light was on, I had started to ask my question before it went off.

Ms. POWELL. And I delayed him by taking long in answering this.

The CHAIRMAN. Thank you.

I think it is Senator Wyden. Yes. Senator Wyden, then Senator Lincoln, then Senator Hatch.

Senator WYDEN. Thank you very much, Mr. Chairman. Thank you for the hearings. It seems to me that the witnesses, both yesterday and today, have delivered a powerful indictment against a number of management practices in the way Medicaid has operated.

I will tell you, I think if you look cumulatively at what has been said yesterday and today, Medicaid is not a smart shopper, nor is it a careful guardian of the taxpayers' wallet.

Yesterday, Ms. Aronovitz, for example, said, in response to a question I made, that the government basically responds to the fraud of the day. When there is a rip-off, the government reacts, but that the government is not thinking strategically.

I think I would like to start with Ms. Powell. You make the point that a lot of the pharmaceutical companies are confused with respect to various guidelines of the Centers for Medicare and Medicaid Services, and essentially that is part of the problem and contributing to the fraud.

I wonder if we might begin by getting on the record, has the Pharmaceutical Association made a formal anti-fraud proposal to the Centers for Medicare and Medicaid Services? If so, if you could just tell us a little bit about what that is.

Ms. POWELL. Senator, I do not believe that we have recently made a formal proposal focused specifically on fraud to the Centers for Medicare and Medicaid Services.We have made comments on the proposed regulations that were issued back in, I believe, 1995 for a number of the aspects of the Medicaid rebate statute.

Those proposed regulations were never finalized, so CMS, in fact, has no regulations that govern any of the Medicaid reporting requirements, the calculation of best price. They have issued a series of notices, sometimes to manufacturers, sometimes to States.

Those notices have been inconsistent at best, and in some cases directly contradictory, so in 1 year they would say do this, and 2 years later they would say, no, under no circumstances do this. So, the manufacturers have difficulty working their way through what it is that is expected of them.

We have urged CMS to go back and issue regulations. At this point, they would need to start with a new proposed rule, and we would be happy to work with CMS in the process of doing that.

Senator WYDEN. I would just hope—and this is going to be part of my focus in fighting fraud—that all of us would be proactive. When you said that pharmaceutical manufacturers did not care for the government's current approach, I was just curious whether you all had offered your own. I appreciate your response.

The second issue I would like to explore with you is the Governors' proposal with respect to deepening the rebates that the Medicaid program would receive.

We are in a very difficult climate, obviously, financially, so everybody is going to have to put something on the table. I looked at what the government was doing now for the pharmaceutical sector. There is protection in trade agreements. There are research grants that are offered. There are tax deductions for research and development, tax deductions for advertising. The list just goes on and on.

In the spirit of sort of sharing the sacrifices, what would be the problem with the part of the Governors' recommendations to deepen the discount, deepen the rebate that would be made available during this time when we are all going to have to try to put something on the table to help Medicaid through difficult times?

Ms. POWELL. Well, first, Senator, let me note that Medicaid is going to see a different budgetary structure come January 1, 2006, because many of the patients within Medicaid on whom the largest amount of drug spending is spent, will be covered through Medicare.

So, in some ways, looking at the Medicaid budget now is a little bit premature until we all see what the direct effects will be of the new Medicare structure. Then, as I noted, prescription drugs actually are approximately 7 percent of Medicaid spending.

I think that, as you look at saving money within the entire Medicaid budget, there are a variety of ways that that can be done. Obviously, each part of the Medicaid budget will at some point make a contribution.

One of the things we have found at the State level, though, is that in a number of States the Medicaid rebate goes back to the State's general fund and does not get back into the State's health care budget, let alone back into the Medicaid budget, so in many cases the Medicaid people do not even get the benefit of having that rebate.

Senator WYDEN. I know my light is on. I will look forward to the second round that the Chairman has graciously agreed to do.

The CHAIRMAN. Thank you very much.

Now, Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman.

Mr. Vito, I would kind of like to follow up on the first question that the Chairman asked about the concerns in the transparency of drug pricing, and particularly drug pricing data. We know there are so many of these acronyms being thrown around, AWPs, ASPs.

What exactly are these labels based on, if not the actual cost of producing the drugs? I guess that is one of the questions. I have heard that the AWP does not even stand for average wholesale price. I have heard it jokingly referred to as "ain't what's paid" in many instances.

So, if we do not even have the complete information, how are we expected to really address drug pricing policies? I guess, how much can you further extrapolate on what the Chairman asked about transparency?

And I guess to follow that up, if we had more accurate pricing information, can you predict that the States would see savings? Any idea of what level of savings they would see if there was greater transparency or accurate pricing information, and is it significant at all?

Mr. VITO. I would like to try to address your questions. The first thing is, the AWP reimbursement. I think we went through what the problems are with that. So what would be a better price? I think that is what you are asking.

It would be prices that would reflect pharmacies' acquisition cost, prices that can be verified and audited, prices that are defined in statute and regulation, and prices that have a penalty for false reporting. Those would be the tenets that you would start with.

Senator LINCOLN. What about the actual cost of producing the drug? I mean, is that not important here? That is what most people do when they have a product.

Mr. VITO. I think what we are talking about is the acquisition cost that pharmacies pay for the drugs. I think you are talking about something different. The work that we have done points out what that pharmacies are able to purchase the drugs for is substantially less than the AWPs that are used to set those prices. So, that is what we are looking at.

Right now, the government has two sets of prices, ASP and AMP. They are both statutorily defined. They are based on actual sales data. So, this information is actual, true sales data.

Senator LINCOLN. But that is based on sales and not what it costs to produce it.

Mr. VITO. I think, again, the question we are looking at as far as the Medicaid side of the issue is, what is the appropriate payment that pharmacies need to get? We are looking at what pharmacies are actually paying for the drugs and making that comparison. You are asking a somewhat different question that I do not have the answer for.

Senator LINCOLN. Just based on all of these acronyms we are using and all of these different ways to get at what we are trying to get at, it seems to me that there should be a little bit of focus in terms of what it is costing in terms of producing these drugs. I do not see that anywhere in the equation that we are using here. So, I do not know if that makes any sense or not, but it does to me.

Mr. Coleman, just recently the Government Accountability Office released a report about CMS's oversight of the Medicaid drug rebate program. As my colleague from Oregon mentioned, there is so much here that really centers around management issues and how we prioritize how we are going to manage these issues, whether or not the taxpayers' money is important enough to us that we require decent management of those dollars and how they come out.

In that report, GAO found that CMS conducts only limited checks for reporting errors in manufacturer-reported drug prices, and only reviews price determination methods when manufacturers request recalculations of prior rebates.

It certainly sounds very responsive to the drug manufacturers. It seems to me, though, that CMS is kind of shirking its responsibility to the taxpayers. I guess my question would be, does the Justice Department step in here, or why does it not?

Mr. COLEMAN. Well, the example that you mentioned, Senator, I think illustrates very well the problems with the pricing mechanisms that are used today in the Medicaid program. The average wholesale price, acquisition cost, some of these other figures are difficult to understand, they are difficult to audit.

For example, average wholesale price is not reported directly to CMS, it is reported in a very decentralized market-based system, which works in the following way. The manufacturers report their prices to a variety of private reporting services, which the States then look to to provide that information.

So, it is not like Medicare Part B, in which pricing information is reported directly to CMS. One of the virtues of the President's proposal on using average sales price instead of average wholesale price, is that that information would be defined by statute and, as in the case of Medicare Part B, would be reported directly to CMS so that CMS would have better institutional capacity to audit that information and make sure it is accurate.

Senator LINCOLN. Well, when we see the report that GAO provided and the estimates of the administration, CMS is not investing in oversight. I mean, they spend $14 million on Medicaid oversight and more than $700 million on Medicare oversight.

I mean, clearly, this is not a priority for CMS to provide the resources for the oversight. I mean, you have got eight employees assigned to fraud and abuse control activities at CMS. That is obviously not a priority.

I guess my question is, and what your answer is telling me is, that you do not feel like you all at DOJ have a responsibility then to investigate whether or not these practices are appropriate for the taxpayer.

The CHAIRMAN. Give a short answer, please.

Senator LINCOLN. Sorry, Mr. Chairman.

Mr. COLEMAN. The short answer is, we have not seen any basis to investigate CMS for any matter within the Justice Department's jurisdiction.

Senator LINCOLN. Thank you.

The CHAIRMAN. Senator Hatch?

Senator HATCH. Thank you, Mr. Chairman.

Welcome, all of you, to the committee.

Let me start with you, Mr. Coleman, but I would like anybody else who would care to answer these questions to speak up and feel free to answer.

Mr. Coleman, your testimony was detailed about pricing schemes connected to the pharmaceutical industry. I have sat through these hearings for 2 days, and, while I believe it is important to hear about these matters, I think it is maybe now the time to place the emphasis more on solutions. What do we do to solve these problems?

I would like to know if any of the panel members have detailed proposals on how to resolve the concerns that have been raised by all of you. It is so easy to paint a picture one way or another and to point fingers and tell Congress what the government is doing wrong, but it is harder to find people who have solutions.

So, I would like to hear any solutions. I am committed to finding solutions, but I would like to hear your thoughts on short-term and long-term solutions so we can resolve these problems once and for all.

Then, also, as you consider answering that, tell us what tools you are going to need from Congress, or anywhere else, for that matter, in order to resolve some of these problems.

Mr. COLEMAN. Thank you, Senator. The take-away from the work we have done on a whole series of long-term investigations of the pharmaceutical industry is that the pricing mechanisms that are used in Medicaid are largely problematic and subject to manipulation.

The Justice Department's view is that the President's proposals on changing those pricing mechanisms would be an effective solution, at least in part, to the larger problem of Medicaid and would also provide us with more effective tools for investigating these cases.

Senator HATCH. What would you suggest they change these pricing mechanisms to?

Mr. COLEMAN. Two points, Senator. First of all, the President has proposed to require that State Medicaid programs use average sales price to determine reimbursements to pharmacies for Medicaid payments. Average sales price, as Mr. Vito can speak about more effectively than I can, is defined by statute.

The information in Medicare Part B is reported directly to CMS. It is auditable. There could be penalties for failure to report it accurately. It is not a decentralized system that relies on private reporting services, like average wholesale price. So, that is one proposal.

The second proposal is replacing the concept of "best price" to be used in the determination of the amount of rebate that is owed under the drug rebate statute, to replace that with a flat rebate.

So, those are two of the President's proposals that, in our view, would go a long way toward preventing manipulation of drug pricing and would also give us tools to help investigate cases where manipulation occurs.

Senator HATCH. Mr. Vito, what is wrong with that? Are those two suggestions good suggestions?

Mr. VITO. Oh, yes. We have some suggestions. The first one would relate to the Federal Upper Limits. We suggest that CMS work with Congress to get a better estimate of what to base the Federal Upper Limit drugs on.

Our work today demonstrated, if we used sales-based pricing that is defined in statute and regulation, and we multiplied the average AMP by 150 percent, that there would be significant savings that the government can achieve just in one quarter. So, that is one of the answers.

The other answer is, it comes back again to, what is a better price? I want to again point out that CMS currently receives two types of pricing information that are statutorily defined based on actual sales data and can be audited and can be verified, and there is a penalty for false reporting. Both the AMP and the ASP have that information.

In addition to that, the Medicare Modernization Act has provided more responsibilities to the Federal Government, in the Office of Inspector General, to monitor the average sales price.

The Inspector General, as part of the Medicare Modernization Act, is required to go out and determine widely available market prices to ensure that ASP prices are prices that prudent physicians are purchasing the drugs for.

They have given the authority to the Inspector General, if we identify situations where the prices are less, then we can report that to the Secretary, and the Secretary can take action to lower that price.

But the point that I am trying to make, in addition to that, is that if manufacturers and wholesalers refuse to give pricing information, then they can be fined.

So the bottom line is, the two pricing systems that CMS currently has are much better than the pricing system that it has currently used, which is AWP, for the number of reasons that I explained.

Senator HATCH. Ms. Powell, can you live with those suggestions?

Ms. POWELL. Those are clearly interesting suggestions. On the elimination of the best price, I would just note that the best price provision does not apply to generic drugs, but there has been testimony that there have been problems with generic drug products as well.

Senator HATCH. If the pharmaceutical industry had its choice, what would you suggest we use for solutions here?

Ms. POWELL. Well, we have consistently said that the first solution should be clear and consistent regulations from CMS. We know that CMS has been incredibly active in issuing regulations and guidances for the implementation of the Medicare drug benefit, and other aspects of the MMA.

So, we think that in the Medicaid context, they are moving in the right direction. The first thing they need is to provide in advance clear direction to the manufacturers and to everybody else within the system.

Senator HATCH. And you do not think the directions are clear now?

Ms. POWELL. We do not think the directions are clear now for any aspect of the Medicaid drug rebate. There are, in fact, no existing regulations. There are guidances that are inconsistent.

Senator HATCH. Ms. Manning?

Ms. MANNING. I would like to comment on that a bit from my experience inside a drug company. I would like to comment in terms of all of the pricing mechanisms that I see before me.

In reality, none of these pricing mechanisms would address the types of problems that occurred within Schering-Plough, where there were massive rebates in disguise going to major insurers and major HMOs that would bring the prices well below any of the prices there.

I also think the concept of best price to the government makes some business sense to me. For most drug companies, the major purchaser—30 percent was the case at Schering-Plough—is the government.

The justification that drug companies use for giving discounts to big for-profit insurers is that that is a big volume. I think the government has an even stronger case to make on that point than any of the big private insurers.

Senator HATCH. Mr. O'Connell?

Mr. O'CONNELL. I have been restraining myself to jump up and wave my hands. Texas, for over 20 years, has had a set of rules and regulations that required drug manufacturers to report real pricing. It was a very plain regulation: tell me what you sell your drugs for to wholesalers and distributors; tell me what you sell your drugs for to chain warehouses.

So, Texas has done, over the last 20 years, what I think the Congress needs to do for all the other things. However, we still got cheated. The problem is—and I want to make sure you understand, this is not every manufacturer, and I do not think it is a majority of the manufacturers—I think what Ms. Manning says: when you have a corporate culture that says, I am going to figure out a way to get around this regulation, the more defined the numbers are, the more they can be audited, the better off we are.

But in fact, in our case, the defendants have said, I did not know what you meant by "price to wholesaler." I did not know what that meant. What was the definition of that? It is an absurd response, because the answer is, what did you sell it for?

Senator HATCH. Well, so far, I am not sure what the solution is here. There seems to be some element of disagreement here.

But you are saying, Ms. Powell, that it needs to be something that the drug companies understand and that is simple enough for them to understand. We would like you to give us your best advice in writing, if you would, because we want to get this right.

It is a huge expense. Forty-five percent of our population uses a prescription drug, according to what I have heard. It seems to me, we ought to come up with some system that really will work and that gives due notice to the pharmaceutical industry so that they do not get caught in the web of contradictory approaches where they could be indicted or could have difficulties, and where they know, if they do not abide by it, they are going to get clocked. It is just that simple. I would like to see you come up with the very best recommendations you can for us.

The CHAIRMAN. Senator Schumer?

Senator SCHUMER. Thank you, Mr. Chairman.

I want to thank the witnesses.

My question is about authorized generics. Almost everyone in this room would agree that the Medicaid program pays too much for prescription drugs, and we can debate why.

Some is because of fraud, some deceptive practices by some of the drug companies, and some is due to policies that we have set that favor pharmaceuticals and keep drug prices high. There are definitely steps that Congress can take to reduce spending in Medicaid, but there are also steps that CMS should be taking now.

So, both Mr. Vito and Mr. Coleman, in their testimony, discussed two settlements totaling $350 million, one against Bayer, one against GlaxoSmithKline, based on the companies' use of a private labeling scheme to evade the best price.

In these cases, the companies put a new label on the drug, sold them at a lower price, and under a different new drug code than other versions of their brand drug, and they did not report this to Medicaid.

This is exactly the model that brand-name drug companies are using to market so-called "authorized generics," generic label packages of their brand drugs. They are putting a new label on the drug, getting a different new drug code, selling it at a lower price, and not reporting this price to Medicaid.

Just because this practice is being conducted in the open does not make it any less of an abuse or fraudulent manipulation of the system. In fact, it makes it more outrageous. Brand company tactics, exactly like those which led to the Bayer and Glaxo settlements, are cheating Medicaid out of its rightful rebates.

Perhaps the most shocking aspect of this abuse is that it is one which could be ended by a simple stroke of the pen, a change in policy by CMS or on behalf of CMS. I have urged Secretary Leavitt and Administrator McClellan to make the policy change, but to my knowledge CMS has taken no action to stop this abuse and achieve these savings for Medicaid.

So, I would like to ask Mr. Coleman, Mr. Vito, and Mr. O'Connell, could you tell me, please, what steps the Department of Justice, the Office of Inspector General, and the State Attorneys General, respectively, are taking to investigate this practice and take action against companies who have cheated Medicaid out of rebates by using authorized generics.

We will start with Mr. Coleman.

Mr. COLEMAN. I cannot take a position or comment on that issue on behalf of the Department of Justice. We are prosecutors, we are civil litigators. We enforce the law and the policy as it is and we just do not have the institutional capacity.

Senator SCHUMER. You could look at cases, the way you did with Glaxo, Kline, and Bayer. Why have you not done that?

Mr. COLEMAN. Certainly, if cases are brought to our attention by relators or others——

Senator SCHUMER. I am bringing it to your attention right now. What are you going to do?

Mr. COLEMAN. We would certainly be happy to look at the information. If there is a predicate for initiating a criminal investigation, we will do that.

Senator SCHUMER. I just want to ask you, as a lawyer, why is the predicate any different with authorized generics than it is with what you did in the Bayer, Glaxo, and SmithKline cases?

Mr. COLEMAN. As you pointed out, Senator, the policy that has been adopted by CMS, presumably, allows for this conduct and the conduct was conducted out in the open, as you characterized it. So it is not the kind of case that we——

Senator SCHUMER. Do you see any difference in the fact pattern, forgetting whether it is open or not?

Mr. COLEMAN. I do not know enough about the facts to comment on that.

Senator SCHUMER. Thank you.

Mr. Vito?

Mr. VITO. I think that is an excellent question, Senator Schumer, and I will be glad, if you would like for us to check, to see what CMS has done on this issue. If you are interested in us getting involved in any work, we would be glad to meet with you and work with you to get that done.

Senator SCHUMER. All right. I am glad you said you would do that. I think I have written you on this and you said you are going to start.

Do you have any idea, has such an investigation started, or an examination, if you want to call it that?

Mr. VITO. At this time, I do not.

Senator SCHUMER. And you would want the Office of Inspector General to undertake such an examination?

Mr. VITO. I will work with the Office. I will bring your point to the Inspector General's Office and we will have a discussion, and we will get back to you with the results of that discussion.

Senator SCHUMER. Do you see any difference, just off the top of your head, other than, one is open, one is not, one is generics, one is not, between the Bayer, Glaxo, SmithKline situations and the authorized generic situation?

Mr. VITO. I am sorry, Senator, I really do not know enough to talk about that in detail.

Senator SCHUMER. All right. I would ask if I could, Mr. Chairman, in writing, get an answer on that issue from Mr. Vito.

The CHAIRMAN. Yes.

Senator SCHUMER. Now, just Mr. O'Connell?

Mr. O'CONNELL. Senator Schumer, like Mr. Coleman, I am a litigator. I have to follow the Texas law. The Texas law, the Medicaid Fraud Prevention Act, says I can only pursue people for something that is a violation of Federal or State law.

Our investigation, for example, in the Schering case, clearly shows that they created their own generic, marketed. As long as they report accurately to us what they are selling it for and accurately report and pay their rebate that they are required to by law, I do not think it is a violation of the Medicaid Fraud Prevention Act. However, we would be happy to look at it again and work with you.

Senator SCHUMER. What do you think of it, from a policy basis? Here we are, everyone says we have to save money for Medicaid. Here is a classic example where we could, with no harm to anybody, except maybe profit margins of the pharmaceutical industry, and we are not getting any results.

The only reason I could see for that is, somebody wants to be nice to the pharmaceutical industries as opposed to being nice to the Medicaid program, the taxpayers, and the consumers.

Mr. O'CONNELL. Like Mr. Vito, I am not sure I can speak to the policy.

Senator SCHUMER. All right.

Let me just ask, what do you think, Ms. Manning?

Ms. MANNING. I am not going to speak directly to that. But I can say it was our experience, over the length of our case, that the actor that was the least interested in pursuing the case was CMS, and sometimes would have preferred that the U.S. Attorney was not pursuing the case as aggressively as they were. I think, had it not been for our U.S. Attorney's being persistent, this could well have not come to——

Senator SCHUMER. I am going to do my best to see that CMS is a little more interested this time, maybe with the OIG's help, let us hope.

Thank you, Mr. Chairman.

The CHAIRMAN. I have a second round of questions, and Senator Wyden did, too.

I left off with Mr. Vito. I wanted Mr. O'Connell to speak to the point. I am going to go back through the whole question.

It is my understanding that the State of Texas is one of the lead litigants in a case that just came out of seal from Federal Court, San Antonio. The case alleges fraud of the Medicaid program resulting from third-party liability.

Now, you cannot speak on specific, ongoing litigation cases, but I was wondering if, based on the case, you believe there is a change in Federal law that would help to prevent the losses of Medicaid that exist because of third-party payors.

Mr. O'CONNELL. Yes, Senator. In that case, a relator brought to us allegations that one of the major pharmacy benefit managers, Caremark, was purposely not paying Medicaid for requests for reimbursement for people who were eligible under both plans covered by Caremark, as well as Medicaid.

We obtained in our discovery with that PBM, basically, their computer run of every person who was covered by their plans.

When we did that, we found that there were over half a million claims that Medicaid could have requested reimbursement for, but we had no knowledge of the fact that those individuals were covered by plans managed by Caremark.

There is no law requiring pharmacy benefit managers, or any insurance company, or companies who provide insurance coverage for their employees, to report which individuals they cover.

We think that it would be appropriate, it may be very efficient and effective, for reporting of those covered lives to go to one central place—I assume CMS—where the State Medicaid programs could then match up the individuals on their Medicaid programs and see if they are missing claims for reimbursement. For example, an average pharmacy reimbursement claim, I believe, is about $30. So if you miss a half a million, it adds up.

The CHAIRMAN. All right.

Now, to Mr. Vito on another point. The prescription drug bill that we passed in 2003 changed the basis of Medicare's drug reimbursement formula from AWP to a statutory figure based on actual sales. Would a similar change help fix the problems of Medicaid reimbursement?

Mr. VITO. We believe that the current system, based on AWP, does not represent the actual acquisition cost for pharmacies. We believe that if you change to a system that is statutorily defined based on actual sales data, and can be audited and verified, and there are penalties for falsely reporting, then I think there would be great opportunity for the program to save money.

The CHAIRMAN. Thank you.

Now, Ms. Manning, we have heard a lot about the False Claims Act and its use to help deter the type of conduct that you have so well described to us today.

When did you first learn about the False Claims Act and what do you think the deterrent effect would be if corporate executives knew that all corporate employees were fully aware of the False Claims Act?

Ms. MANNING. I first heard about it from my lawyer, whom I had consulted on an employment matter after siding with a secretary who reported being sexually harassed. So, I think there is not very broad knowledge out there at all, and I would say, still.

I think it has the potential of having a noticeably chilling effect on executive management if they were sure all of their employees knew how to report fraud.

The CHAIRMAN. All right. Thank you.

Mr. Coleman, we have heard testimony that there is somewhere in the ballpark of 100 lawsuits currently under seal in the courts across our country. I understand that these cases are under seal and that you cannot speak specifically on any of them.

But could you describe the types of problems that these cases present? Are they new types of fraud that we have not seen, or are they more of the same types that we have seen and are currently dealing with?

Mr. COLEMAN. Two points, Mr. Chairman. We do expect to see more of the same. Of course, I cannot get into any specific cases, but we do have under active investigation a substantial number of cases that deal with issues like the issues we have been discussing today. The second point is, we expect to see a significant volume of off-label marketing cases like the case that I mentioned earlier.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you. Thank you very much, Mr. Chairman.

Mr. Coleman, I ran a legal aid office for the elderly, and when we would see rip-offs of seniors or taxpayers and see a pattern, we would essentially call up the relevant agency and give them a heads up, and say, this is what is going on.

Do you do that with CMS? I mean, do you regularly get on the phone with CMS and say, look, we are seeing these kinds of cases?

Mr. COLEMAN. We do. We coordinate regularly with CMS. We have a quarterly meeting, not just with Justice and CMS, but with representatives from OIG and other agencies that we work with.

We do have a continuing dialogue. We have career people in the Department who have been working on these issues for years who coordinate with their colleagues at CMS. So, there is a lot of communication, there is a lot of coordination that goes on. Perhaps part of the challenge of that coordination is that we, again, are prosecutors, we are civil litigators. We enforce the law that is on the books.

Senator WYDEN. A question for you, Ms. Powell, about the direct-to-consumer advertising issue. I know your association is putting together a code. I would like to get for the record whether you agree that a purpose of advertising is to increase the number of people who take the drug.

Ms. POWELL. The purpose of advertising is to ensure that patients, who may have a condition for which the drug would be appropriate, are aware that the drug is available, but to also make sure that patients are aware that there are both benefits and risks.

The purpose is clearly not solely to increase the market of a drug, because prescription drugs are for specific purposes. A patient who does not have a given condition should not be taking that medication.

Senator WYDEN. Well, you have said the purpose is not solely increased utilization, but a purpose is to increase utilization. That, of course, can drive up the prices for Medicaid, and that gets me to the question I would like to ask.

Nexium is a blockbuster seller, and Medicaid is paying for the advertising costs for Nexium. Now, I would not do anything to censor those ads. I would not take away the tax breaks for pharmaceutical companies' advertising. But what is Medicaid's interest in paying for those Nexium ads?

Ms. POWELL. Actually, my understanding, Senator, is that in many instances the costs of drugs that are advertised does not increase because of the advertising, but Medicaid's interest in paying for those drugs is to provide a health benefit to patients.

I cannot talk about the specifics of any individual drug, but I do know that there are instances where a patient who has a medication that they will actually take consistently and on a schedule, patients will get better.

One of the issues that occurs with a variety of drugs is, patients either stop taking them or take them only once a day when, in fact, they should be taking them multiple times a day. There have been studies that have shown that when drugs are advertised, it reminds patients who have a prescription and should be taking the drug, to take that drug.

Now, clearly, advertising is not the most effective way to teach a patient how to take their medicine consistently, but that is one of the side effects of advertising.

But we consistently say that we believe that Medicaid should be paying for the appropriate drug for any given patient, and that is a decision that needs to be made between the patient and the physician or the prescriber.

Senator WYDEN. What troubles me about the position that you have announced, that Medicaid should pay for appropriate drugs—which of course is something that I strongly agree with—it is not responsive to the question, which is, what is Medicaid's interest in paying for the ads?

The ads are already going on the television sets all across the country. We see the ads every few minutes, those purple pills dancing across our TV sets. So, the ads are already going across the country. There is a tax break for running the ads.

But Senator Sununu and I have said, on a bipartisan basis, we do not see what the taxpayers' interest, Medicaid's interest, is in paying for those ads. They are already being paid for once with the tax breaks. Then Medicaid is being soaked again, which does not seem to me to be in the public interest. I want to let you have the last word.

Ms. POWELL. I am not aware of your legislation, so I cannot comment directly on that. But if a physician believes that, whatever the medication, Nexium or any other drug that is advertised or not advertised, is the appropriate drug for that patient and the patient is a Medicaid or Medicare patient, then Medicare or Medicaid would be paying for that medication.

Senator WYDEN. Mr. Chairman, you were very thoughtful to give us two rounds, and I thank you.

The CHAIRMAN. Yes.

Senator Hatch? Then when Senator Hatch is done, I will call the next panel.

Senator HATCH. Ms. Powell, how many prescription drugs are in the marketplace?

Ms. POWELL. My understanding is that there are something like 10,000 medications that are on the market.

Senator HATCH. Sometimes people would have no idea that there might be a possible remedy to some of their problems without at least somebody telling them that there might be a remedy through advertising.

Ms. POWELL. Well, that is, in fact, one of the reasons that manufacturers make a decision to advertise for individual prescriptions.

Senator HATCH. I hope you can talk about this. You can make the manufacturers look like terrible people, or you can say, well, they are in business and they want people to understand, they have a drug that might work.

Ms. POWELL. Well, in fact, some of the disease advocacy organizations report that when there is advertising for a new product for a particular disease, they see an increase in the number of people calling, asking for information about that disease.

Senator HATCH. That stands to reason.

From what I have heard today, though, it seems that any problems in the Medicaid drug rebate formula stem largely from the lack of government guidance to drug manufacturers, not in any sort of problem with the basic rebate formula contained in current law. Am I wrong on that? Or what are your thoughts on that?

Ms. POWELL. Our position has consistently been that, once the statute was established, there should have been regulations. Now that the law has been in effect for approximately 15 years and there are still no regulations, and the perception by both government agencies and the people within the health care system, the PBMs, the pharmacies, the State government Medicaid agencies, that behavior that was acceptable 10 or 15 years ago is now no longer acceptable, is creating a situation that puts manufacturers in a difficult position, and that clear guidance, consistent guidance, would go a long way to allowing manufacturers to make a good-faith effort to try to be compliant with the law.

Senator HATCH. I would be interested in your suggestions to us, as people who have to resolve the Medicaid problem, as to how we might give clear guidance, maybe statutorily if you are not getting it from a regulatory standpoint.

But let me ask you this. What has the pharmaceutical industry done to foster better operations of drug reimbursements under Medicaid? If you have done something, what more can be done?

Ms. POWELL. Well, we have worked with a variety of State agencies and with State legislatures on the issues that they face in structuring their process for reimbursement.

For example, the State of California is in the middle of developing regulations for ASP reporting, which the State of California is going to be moving toward for its Medicaid program.

We have submitted a series of comments and agreed to work with the agency as it tries to develop its regulations for how manufacturers will calculate ASP and how the State will then work from that ASP to provide reimbursement, not only to pharmacies, but to clinics that may be administering medications, to hospitals that are administering medications that are covered by Medicaid.

Senator HATCH. Now, some have said that drug manufacturers determine average wholesale price. Could you talk about this to the committee? I would be interested in your industry's perspective on AWPs.

Ms. POWELL. Well, my understanding—and I have not ever worked within an individual company, and I do not have information about individual companies' pricing because of the antitrust laws—is that average wholesale price is reported by Redbook and other commercial entities, and that they, in fact, either take average wholesale prices reported to them by manufacturers or they take a manufacturer's price list and increase that by some unknown percentage, and then report an average wholesale price.

Senator HATCH. One last thing. I think there are cases where the pharmaceutical industry over-advertises, but I also think there is another side to that coin, too. For instance, not only do you have—to use your figure—10,000 prescription drugs out there that may or may not be perfect for various individuals and their maladies, but you have hundreds of thousands of doctors who may or may not understand what pharmaceuticals are there.

I used to be a medical liability defense lawyer in my practice. I have to say, there were doctors who really were pharmacological experts and there were some who basically just listened to whatever the scuttlebutt was on various pharmaceuticals.

So, is it not true that sometimes the pharmaceutical companies advertise so even doctors can see those ads and say, well, that might be something that would help Rosie over here?

Ms. POWELL. Well, I think there are a variety of sources that doctors get information about drugs and about other kinds of new treatments. One of them is advertising.

Senator HATCH. That is not just television, it is print advertising and a lot of other things.

Ms. POWELL. In fact, the large majority of physician education about drugs comes not from the television or broadcast advertising, but from individual information that is provided directly to not only physicians, but to everybody within the health care system, because there are other prescribers and there are other people in physicians' offices who may be giving patients advice about how to be taking their medications.

Senator HATCH. Mr. Chairman, this has been an interesting hearing. I want to commend you for conducting it and going through this. We have to find some ways of cutting down prices, but also make sure we do not kill one of the best industries in America that has a positive balance of trade set of payments as well.

The CHAIRMAN. Yes. I agree with you.

Senator HATCH. I appreciate all of you for your testimony here today.

The CHAIRMAN. Yes. I agree with you. You can tell by the questions that were asked, and the attendance at this hearing, the importance of your testimony. It comes at a time when we are working with a bipartisan group of Governors to see what we can do to save some money in Medicaid, but also to continue to serve people that need to be served, with the idea that we will not be taking classes of people off the Medicaid rolls. So, we thank you very much.

Now, will the other witnesses come while I introduce you? Our first witness is actually two witnesses: Daniel O'Brien, representing Erickson Retirement Communities as senior vice president. Mr. O'Brien is here to testify about Erickson Retirement Communities' efforts to contractually require residents to spend down personal assets and qualify for Title 19.

Then we also have Ruth Pundt from Erickson, a resident of one of the Erickson facilities in Maryland. She joins us to provide testimony about her experience with other residents of the facilities that have utilized various mechanisms to transfer assets and use Medicaid for long-term care. I am glad that she could join us, and I appreciate her testimony.

Then we have Julie Stone-Axelrad, Specialist in Social Legislation at the Congressional Research Service. Ms. Stone-Axelrad is here to provide testimony regarding the various mechanisms that exist allowing an individual to transfer assets to qualify for Medicaid. She will also provide some background on Congressional efforts to curb the transfers, and a brief introduction to a video of a company that promotes asset transfers as a tool for long-term planning. That video is actually very long, but we are just going to have a short snippet of it, as far as I can tell.

Our next witness will be Paul Pickerell, manager, Financial Recoveries Division, Oregon Department of Human Services. Mr. Pickerell is testifying regarding the law of estate recovery and the success of Oregon in enforcing this important provision.

Joyce Ruddock represents the long-term care insurance industry. She is vice president of Long-Term Care Division at MetLife. She is also representing the American Council of Life Insurers. Ms. Ruddock will testify about the long-term care industry and the opportunities that exist for the Federal Government to partner with the private sector to enroll individuals in long-term care insurance.

And Judy Feder is dean at the Public Policy Institute, Georgetown University, and is here to provide testimony regarding asset transfers, estate recovery, and long-term care.

I thank all of you. We will go in the order that you were introduced.

So, Mr. O'Brien and Ms. Pundt?

STATEMENT OF DANIEL K. O'BRIEN, SENIOR VICE PRESIDENT, ERICKSON RETIREMENT COMMUNITIES, PARKVILLE, MD; ACCOMPANIED BY RUTH PUNDT, RESIDENT FROM ERICKSON RETIREMENT COMMUNITIES, PARKVILLE, MD

Mr. O'BRIEN. Thank you, Mr. Chairman. It is a privilege to have the opportunity to appear before you and the members of the committee.

Erickson Retirement Communities serves middle-income seniors by providing a continuum of care—independent living, assisted living, nursing care—all on an integrated campus and purchased under a single contract. A typical Erickson community serves about 2,300 residents in one location.

When residents move in, they pay an entrance fee. It is a sizeable amount of money, ranging from $100,000 to $400,000. They also pledge their other assets that would be available to fund their long-term care needs.

That way, as people age in place, if they go to the nursing home, under our contract they have obligated themselves to spend their outside assets first, then spend down the entrance deposit that would be otherwise refundable if they did not spend it down, and then access Medicaid as a payor of last resort, which is, I guess, becoming a novel concept.

That system worked well for over 20 years. Over the last few years, however, some fairly astute Medicaid planning attorneys have worked with a few of our residents to allow them to gain access to Medicaid prior to having spent down their entrance deposits.

So, while we were holding hundreds of thousands of dollars of these residents' money that they had contractually made available to fund their long-term care needs, these people were accessing Medicaid with the assistance of these attorneys.

When we went to the State of Maryland where this first occurred, the State of Maryland said that they viewed that this entrance deposit should be an excluded asset for the purposes of calculating Medicaid eligibility, which we thought was sort of a ridiculous finding, and ended up pressing the matter with CMS.

Before doing that, though, we went to our residents and we asked them their perspective. In fact, we even had estate planning attorneys calling us to ask if they could increase the size of the entrance deposits that we were holding on behalf of our residents as a Medicaid avoidance prospect.

We went to our residents and actually presented the issue before our residents. Mrs. Pundt will give you the residents' perspective on that, and then I will finish up with a couple of policy recommendations.

The CHAIRMAN. Ms. Pundt?

Ms. PUNDT. Thank you very much, Mr. Chairman and committee, for allowing me to come here today and give my testimony.

I understand Congress has decided to take up the issue of whether or not they will, once and for all, close the loophole that has allowed continuing-care retirement community residents to access Medicaid without first spending down their entrance deposits.

The residents at Oak Crest Village signed a contract to do this, and I intend to fulfill my contract. Other residents should be required to fulfill their contracts also. As a taxpayer, I believe people with assets should not be able to use loopholes to preserve those assets and shift the burden of paying for their care to others.

America is certainly feeling a budget crunch right now, and the consequences could be severe. With Federal dollars dwindling, there is pressure to cut Medicaid budgets and other critical programs, actions that could devastate our most vulnerable citizens, particularly the poor and seniors.

If the Federal Government allows people who have hundreds of thousands of dollars in CCRC entrance deposits to access Medicaid, it will hurt Oak Crest Village and take money away from the truly needy of our country and the State of Maryland.

I moved to Oak Crest because of the outstanding quality of care there. Allowing undeserving residents to access Medicaid will adversely impact that quality of care, and Medicaid should not be used to preserve inheritances at the cost of providing high-quality care to seniors and our needy citizens.

Most of the residents support closing this loophole with me, so please support closing it, and thank you very much.

The CHAIRMAN. Thank you very much for your practical testimony.

Go ahead.

Mr. O'BRIEN. One example of this. We had a couple move to Oak Crest. They reported over $500,000 in assets. Within 4 months of the couple moving in, the husband was in the nursing facility and was on Medicaid, despite the fact that they had a half a million dollars. They did that in violation of our contract. We took them to court over this.

The Maryland Court of Appeals said that our contract was illegal because they had engaged in legal Medicaid planning, and the fact that we were participating in the Medicaid program sort of obfuscated our ability to enter into a contract that would encourage people to privately fund their long-term care.

It seems to me that it would be in the government's best interests to encourage people to privately fund their long-term care rather than encourage people to subvert the system and divest themselves of their assets and become Medicaid-eligible.

So, in conclusion, I would like to propose a couple of recommendations. Number one, that we would encourage seniors, as I said, to privately fund long-term care needs by clarifying that CCRC contracts that require residents to spend disclosed assets prior to qualifying for Medicaid, that those contracts would be enforceable.

Second, to clarify the statute that CCRC entrance deposits that are available to pay for long-term care must be spent, again, prior to accessing Medicaid rolls. On a more general basis, we ought to clarify the policy intent of Congress that Medicaid is the payor of last resort.

The courts are increasingly finding that that is not the case and that these rules exist in order to help people shelter their assets, and that is the purpose of the rules instead of the rules existing to make sure that everyone receives care.

We ought to close loopholes that treat income and assets differently, allowing the use of annuities to shelter assets and significant sums of money. We ought to lengthen the 3-year look-back period, and we ought to increase the penalties for inappropriately gifting assets.

Last year, Maryland cut the Medicaid budget $74 million because of budget issues. So what they were in essence saying is they cared more about the inheritance rights of 50-year-olds than they did providing adequate care to the truly needy. It seems to me that this is incredibly wrong-headed.

If Congress wanted to debate whether we ought to pay for everybody's health care, we could have that debate. But right now, under the current rules, the government pays for the poor and it pays for those who are wealthy and sophisticated enough to hire an attorney and shelter their assets so middle-income people and people who are willing to play by the rules are the only ones who pay their own way. That seems to me to be patently unfair, and I would encourage Congress to act to change that.

[The prepared statement of Mr. O'Brien appears in the appendix.]

The CHAIRMAN. All right.

Before Ms. Stone-Axelrad goes ahead, I want to introduce this video, which will be very short. I have already referred to it.

The video is designed as an educational tool to help individuals learn how to transfer assets to family members to qualify for Medicaid. The Medicaid Asset Protection Plan is a prime example of the type of legal shenanigans that individuals can play and still qualify for Medicaid to pay for long-term care. The portion that we will watch discusses what the company calls Medicaid Miss, and outlines how to shift assets.

[Whereupon, a video was played.]

The CHAIRMAN. Ms. Stone-Axelrad, please proceed.

STATEMENT OF JULIE STONE-AXELRAD, SPECIALIST IN SOCIAL LEGISLATION, CONGRESSIONAL RESEARCH SERVICE (CRS), WASHINGTON, DC

Ms. STONE-AXELRAD. Good afternoon, Senator Grassley. My name is Julie Stone-Axelrad, and I am a Health Policy Analyst at the Congressional Research Service.

The Medicaid program is means-tested and covers about 54 million people across the Nation, including children and families, people with disabilities, pregnant women, and the elderly. Although the program is targeted at low-income individuals, not all of the poor are eligible and not all of those covered are poor.

Today's discussion about Medicaid estate planning focuses on a subset of Medicaid beneficiaries aged 65 and over who need long-term care and have income greater than SSI's cash benefit of $579 a month.

Medicaid law allows States to cover people whose income reaches, or is sometimes greater than, about 218 percent of the Federal poverty level, but only if they require the level of care that is offered in a nursing home.

States may also extend coverage to people who have medical expenses that deplete their income to specified levels. To qualify, individuals must also meet States' asset standards, which usually follow SSI program rules.

These standards generally allow individuals to retain $2,000 in countable assets, as well as certain types of non-countable or exempt assets, such as an applicant's home, a car, and certain types of annuities. Other rules apply to married couples in which one person seeks Medicaid's long-term care services and the other does not.

Some people meet Medicaid's eligibility standards by having income and assets that are equal to or below a State's specified thresholds. Others deplete their income and assets on the cost of their care, and still others may choose to divest their assets to qualify sooner than they otherwise would.

Despite Congress' efforts to discourage Medicaid estate planning through the design of eligibility asset transfer and estate recovery provisions, current law does not preclude all available means people may use to protect assets.

At the request of the committee, I have included some examples of methods people may use to avoid estate recovery or obtain Medicaid coverage while using personal resources for other purposes, such as giving gifts to children or maintaining a certain living standard.

First, transferring some assets to minimize the length of the penalty period. Medicaid law specifics that penalties for improper transfers begin on the first day of the month in which assets are transferred. These penalties are periods of ineligibility, in months, for certain long-term care services.

One option would be to transfer part of one's assets while using the remainder to pay for one's care until the penalty period expires.

Second, avoiding the look-back period. Any transfers made within 36 months of application to Medicaid, and 60 months for certain trusts, are subject to penalties. Any transfers made prior to these look-back periods are not subject to penalties.

Third, converting countable assets into non-countable assets, such as purchasing an annuity for fair market value.

Finally, current law does not restrict how assets above Medicaid thresholds may be used. For example, if individuals have $8,000 above the asset threshold of $2,000, they are free to apply these excess funds toward the cost of their care, or use them for other purposes such as home improvements.

Some methods appear to be unintended consequences of Medicaid law, designed to target people who are poor or have high medical expenses. However, not all methods of transferring assets are necessarily in conflict with the spirit of Medicaid law.

Some observers refer to Medicaid law as having loopholes. Others suggest that there is a lack of consensus about the amount of assets that should be held by people who face high long-term care costs before qualifying for Medicaid.

The law also likely reflects the difficulty in writing legislative language to discourage all methods of transferring assets without inadvertently restricting access to Medicaid safety nets, particularly for people who transfer assets with no intention of ever seeking Medicaid's assistance.

Critics of Medicaid estate planning explain that it diverts public resources away from the most needy to pay for care for those who are less needy. Some critics also assert that people should assume financial responsibility for their own long-term care services before relying on tax dollars to pay for care they could otherwise afford.

Others indicate that people engage in Medicaid estate planning because a nationwide social insurance program covering long-term services for the elderly does not exist. In addition, they explain that Medicaid's countable asset limit leaves people who have long-term care needs without the resources they need to remain at home.

There are insufficient data available to accurately estimate the prevalence of asset transfers today, and none that can reasonably predict whether, or how much, this practice might grow in the future. What we do know is that a significant amount of anecdotal evidence exists about persons engaging in Medicaid estate planning.

We also know that an industry of elder lawyers, specializing in Medicaid estate planning, has developed across the Nation. Court cases at Federal and State levels also point to the prevalence of transfers. In addition, we know that States have expressed a strong interest in curbing Medicaid estate planning and have taken a number of measures to try to do so.

Although data are not available to accurately estimate the quantity of assets that have been protected, it is clear that any protection of assets that results in Medicaid paying for care that would otherwise have been paid with private funds increases Medicaid program costs.

Given what we know, there is no indication that completely prohibiting asset transfers would result in savings that would amount to a large percentage of Medicaid program outlays.

Nonetheless, Medicaid spent $86.3 billion on long-term care services in 2003. Even if only a fraction of spending were saved, this could still help contain overall program costs.

Congress may want to evaluate the various trade-offs between using public dollars to cover people with long-term care needs of various financial means and ensuring that assistance is targeted to those least able to pay for their care.

To better help inform this policy debate, my written testimony discusses all of these issues in much greater detail. Thank you.

[The prepared statement of Ms. Stone-Axelrad appears in the appendix.]

The CHAIRMAN. Before you start out, Mr. Pickerell, I have just been notified that there are two votes. I will have an opportunity to hear you and Ms. Ruddock, but not Dr. Feder, because there are two votes in a row.

So what I am going to do is, I think I will have her give her testimony in my absence, and then I think we will either submit the questions for answer in writing or my chief counsel can ask the questions of the staff, because I will not be able to come back during that period of time.

So, would you go ahead, Mr. Pickerell?

STATEMENT OF PAUL PICKERELL, MANAGER, FINANCIAL RECOVERIES DIVISION, OREGON DEPARTMENT OF HUMAN SERVICES, EUGENE, OR

Mr. PICKERELL. Yes. Good afternoon, Chairman Grassley. I would like to thank you for the opportunity to provide testimony on Oregon's estate recovery program. Our mission is to recover from the estates of Medicaid recipients the cost of benefits provided.

Our process first identifies assets, then tracks them, and finally recovers them when they become available. We believe that Oregon's estate recovery program has been successful within the existing legal parameters because it has developed a number of business practices that have addressed some of the problems inherent in pursuing estate recovery.

Our statistics show that we have recovered nearly 1.5 percent of our Medicaid expenditures. And 1.5 percent may not seem substantial, but it did amount to nearly $19 million in recoveries in Federal fiscal year 2004.

The relative success of our program is predicated, first and foremost, on the skills of the employees that implement the program. They are a dedicated staff who believe in their job.

They represent a diverse mix of experience, background, and education, with legal, paralegal, and property title experience, as well as experience in Medicaid eligibility collections and delivering services directly to clients.

This varied staff background complements and balances our program and ensures that there is sensitivity to families, while at the same time we recover resources that can be utilized to help other low-income senior and disabled clients.

Some of the practices that Oregon recommends are: utilizing the expanded definition of estate, which allows for the pursuit of assets that many existing State probate definitions preclude.

Two, implementing a State-wide electronic notification process that alerts the Estate Recovery Unit of the Medicaid client's death and allows for a review of the electronic narrative of the case history. Such a review can reveal critical facts or information on estate assets sometimes not included on the office notification document.

Three, securing authority to require a request for notice with the county clerk to notify the State whenever client real property is transferred or encumbered.

Four, utilizing an asset change specialist position within estate recovery. This position researches electronic narratives when assets have dropped off during redeterminations of eligibility and assures proper accounting of assets.

Five, utilizing a probate specialist whose primary responsibility is matching new probates filed in the county courts with the database of deceased Medicaid recipients or surviving spouses to ensure that the State is afforded an opportunity to submit its claim in a timely manner.

Six, developing an estate recovery brochure to be included with all Medicaid applications, as well as making it available at all local Medicaid offices that clearly and concisely outlines the estate recovery process. This brochure should also identify a toll-free number that individuals may call to receive additional information on the estate recovery program.

These are just a few of the best practices. I have included several more in my written testimony.

In looking to the future, there is potential to increase estate recoveries by making changes to current law. I would like to touch on a few that we have found in Oregon to be barriers to recovery of Medicaid costs.

Interspousal transfers, which allow the transfer of assets from the spouse which is receiving, or will receive, Medicaid to the spouse that will not receive Medicaid. Under current law, Medicaid recipients can transfer an unlimited amount of assets to the spouse. Estate recovery consists of sending a claim to the estate of a deceased Medicaid recipient.

If the Medicaid recipient is survived by a spouse, no payment is submitted until the surviving spouse passes away. However, the only assets in the surviving spouse's estate available to satisfy the claim are assets that passed from the Medicaid recipient at death to the surviving spouse.

Therefore, assets that went from the Medicaid recipient during his or her lifetime, such as interspousal transfers, are not available in the surviving spouse's estate to pay an estate recovery claim.

Recoveries would be enhanced if we could eliminate the Federal restriction that prevents recovery of assistance provided before the age of 55 for non-institutionalized individuals.

We could also enhance recoveries if we could eliminate the Federal restriction that prevents recovery of assistance from a Medicaid recipient's estate when a surviving disabled child has been disinherited.

To summarize, estate recovery and Medicaid eligibility are two sides of the same coin. Whatever criteria is allowable in establishing eligibility under Medicaid has a direct and measurable consequence on the availability of resources upon which to present a claim when the Medicaid recipient passes away. The two are closely tied together.

Assets may be sheltered, transferred, or in some other manner removed from eligibility consideration. Therefore, what is exempted from resource consideration during the eligibility process has a significant impact on the estate recovery process.

Thank you again for the opportunity to testify.

[The prepared statement of Mr. Pickerell appears in the appendix.]

The CHAIRMAN. I have been told that I cannot keep the hearing going with my counsel, so I am going to just stop it right now. You will have to stay where you are. I will get over there at the end of the first vote, and if they immediately have the second vote, I can vote and run right back. So, pardon me. I am sorry. We usually have other members here whom we can take turns with.

We will just recess for a little while.

[Whereupon, at 12:24 p.m., the hearing was recessed.]

After Recess [12:50 p.m.]

Ms. DISANTO. Good afternoon. We would like to restart the hearing.

Let me just say that Senator Grassley just called and asked that we go on ahead and adjourn the hearing.

Testimony that has not been completed will be placed into the record.

[The prepared statements of Ms. Ruddock and Dr. Feder appear in the appendix.]

Ms. DISANTO. Before the hearing adjourns, we also want to take care of just a few quick housekeeping matters.

First, the record in this hearing will remain open for 10 days, and that will be until July 11. Also, a number of documents were discussed today, and we also saw a portion of a tape regarding asset transfers.

Without objection, those will be submitted into the hearing record, and the exhibit volumes that were also prepared for today's hearing and that portion of the tape that was viewed today.

I guess, hearing no objection at this point, they would be submitted into the record.

[The documents and exhibits appear in the appendix.]

Ms. DISANTO. I want to thank everybody for coming. I apologize to the two witnesses who were not able to provide their testimony today. There are several stacked votes that have just occurred that were not anticipated today.

I thank you very much. The hearing is hereby adjourned.

[Whereupon, at 12:52 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

United States Government Accountability Office

GAO

Testimony
Before the Committee on Finance,
U.S. Senate

For Release on Delivery
Expected at 10:00 a.m. EDT
Tuesday, June 28, 2005

MEDICAID

States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight

Statement of Kathryn G. Allen
Director, Health Care

GAO
Accountability * Integrity * Reliability

GAO-05-836T

GAO
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Highlights

Highlights of GAO-05-836T, a testimony before the Committee on Finance, U.S. Senate

June 28, 2005

MEDICAID

States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight

Why GAO Did This Study

Medicaid—the federal-state health care financing program covering almost 54 million low-income people at a cost of $276 billion in fiscal year 2003—is by its size and structure at significant risk of waste and exploitation. Because of challenges inherent in overseeing the program, which is administered federally by the Centers for Medicare & Medicaid Services (CMS), GAO added Medicaid to its list of high-risk federal programs in 2003. Over the years, states have found various ways to maximize federal Medicaid reimbursements, sometimes using consultants paid a contingency fee to help them do so.

From earlier work and a report issued today (GAO-05-748), GAO's testimony addresses (1) how some states have inappropriately increased federal reimbursements; (2) some ways states have increased federal reimbursements for school-based Medicaid services and administrative costs; and (3) how states are using contingency-fee consultants to maximize federal Medicaid reimbursements and how CMS is overseeing states' efforts.

What GAO Recommends

GAO recommends that CMS improve oversight of contingency-fee projects and states' reimbursement-maximizing methods. Although CMS believes its recent initiatives substantially respond to the recommendations, GAO maintains that additional actions are needed.

www.gao.gov/cgi-bin/getrpt?GAO-05-836T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

What GAO Found

For many years, GAO has reported on varied financing schemes and questionable methods used by states to increase the federal reimbursements they receive for operating their state Medicaid programs. These schemes and methods can undermine Medicaid's federal-state partnership and threaten its fiscal integrity. For example:

- Some states make large supplemental payments to government-owned or government-operated entities for delivery of Medicaid services while requiring these entities to return the payments to the state. This process creates the illusion of valid expenditures in order to obtain federal reimbursement, effectively shifting a portion of the state's share of program expenditures to the federal government and increasing the federal share beyond that established by formula under law.
- Medicaid funding is available for local school districts for certain health services for eligible children and for administrative costs. To claim increased federal Medicaid reimbursement, however, some states and school districts have used methods lacking sufficient controls to ensure that claims were legitimate. GAO also found funding arrangements among schools, states, and private consulting firms where some states retained up to 85 percent of reimbursements for administrative costs. In some cases, school districts paid contingency fees to consultants.

A growing number of states are using consultants on a contingency-fee basis to maximize federal Medicaid reimbursements. As of 2004, 34 states—up from 10 states in 2002—used contingency-fee consultants for this purpose. GAO identified claims in each of five categories of claims (see table) from contingency-fee projects that appeared to be inconsistent with current CMS policy, inconsistent with federal law, or that undermined the fiscal integrity of the Medicaid program. Problematic projects often were in categories where federal requirements were inconsistently applied, evolving, or not specific. CMS has taken steps to improve its fiscal management of Medicaid, but a lack of oversight and clear guidance from CMS has allowed states to develop new financing methods or continue existing ones that take advantage of ambiguity and generate considerable additional federal costs.

Five Categories of Medicaid Claims Reviewed by GAO

Category of claims	Service
Supplemental payment arrangements	Payments to a class of health care providers, such as nursing homes, up to a predefined limit
School-based services	Medicaid-covered medical services provided by schools, such as diagnostic screening or physical therapy, or the administrative cost of providing these services
Targeted case management services	Services to help a defined group of beneficiaries gain access to needed medical, social, educational, and other services
Rehabilitation services	Services to reduce a mental or physical disability and restore an individual to the best possible functional level
Administrative costs	Costs the states incur in administering their Medicaid programs

Source: GAO based on CMS information.

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you explore issues relating to states' efforts to maximize federal Medicaid reimbursements and how they can affect the Medicaid program. Medicaid—the federal-state program financing health care for certain low-income children, families, and individuals who are aged or disabled—covered nearly 54 million people at an estimated total cost of $276 billion in federal fiscal year 2003. Medicaid is the third-largest mandatory spending program in the federal budget and one of the largest components of state budgets, second only to education. The program fulfills a crucial national role by providing health coverage for a variety of vulnerable populations. Congress has structured Medicaid as a shared financial responsibility of the federal government and the states, with the federal share of each state's Medicaid payments determined by a formula specified by law.[1] The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), is the federal agency responsible for the program, and the states design and administer their programs with considerable discretion and flexibility within broad federal guidelines. We have previously reported that the challenges inherent in overseeing a program of Medicaid's size, growth, and diversity put the program at high risk for waste, abuse, and exploitation. In 2003, we added Medicaid to our list of high-risk federal programs.[2]

States can design and administer their Medicaid programs in a manner that helps them ensure that they receive the maximum allowable federal share of expenditures they incur for covered services provided to eligible beneficiaries under a CMS-approved state Medicaid plan, as long as they do so within the framework of federal law, regulation, and CMS policy. To that end, states can employ consultants to assist them in performing a number of valid Medicaid-related functions that may help them to identify and implement ways to obtain additional federal funds or that may help save money for both the federal government and states. Consultants, for example, can help identify claims that are inappropriately paid or that are subject to recovery from other payers.[3] States may choose to pay consultants on a contingency-fee basis (that is, a percent of the additional federal reimbursements they generate for the state) to develop various types of reimbursement-maximizing projects.[4] In the current environment of steadily rising Medicaid costs straining federal and state budgets, states' use of contingency-fee consultants to maximize federal reimbursement can be problematic if controls are inadequate to ensure that additional federal reimbursements are allowable Medicaid expenditures. We have earlier reported on (1) certain types of financing schemes that involved some states making illusory payments to government-owned or government-operated entities such as nursing homes or hospitals, often through a mechanism known as intergovernmental transfers (IGTs),[5] to obtain increased federal reimbursements and (2) concerns with practices used by states and school districts to boost federal payments for school-based services.[6] As part of our body of work on Medicaid financing issues, today we are releasing a report, undertaken at the Chairman's request, that addresses states' use of contingency-fee consultants to maximize federal Medicaid reimbursements.[7]

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[1] By a formula established in law, the federal government matches from 50 to 83 percent of each state's reported Medicaid expenditures for medical assistance. States with lower per capita incomes receive higher federal matching rates. The federal government also matches states' costs for administering the Medicaid program, generally at 50 percent.

[2] GAO, *Major Management Challenges and Program Risks, Department of Health and Human Services*, GAO-03-101 (Washington, D.C.: January 2003).

For today's hearing, you asked us to address issues we have identified in our past and current work concerning some reimbursement-maximizing strategies used by some states and CMS's oversight of them. In my testimony, I will describe: (1) how, over the years, some states have inappropriately increased federal reimbursements, sometimes using IGTs, through varied state financing schemes; (2) how states have used questionable methods to increase federal reimbursements for school-based Medicaid services and administrative costs and the status of CMS's actions to improve oversight in this area; and (3) how states are using contingency-fee consultants to maximize federal Medicaid reimbursements and how CMS oversees states' reimbursement-maximizing strategies. My testimony is based on several previous reports and testimonies, including the report we are issuing today, assessing states' Medicaid financing methods and federal oversight of them. The work that produced these reports and testimonies was conducted from June 1993 through June 2005 in accordance with generally accepted government auditing standards.

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[3] Consultants can provide a wide range of services to states for their Medicaid programs. States that lack sufficient in-house resources can turn to consultants to add staff or needed expertise. Contingency-fee consultants are particularly attractive to budget-constrained states because the states do not need to pay them up front. Consultants can help states by performing services such as identifying new methods or projects to maximize federal Medicaid reimbursements, training state and local staff in procedures for documenting and submitting claims, and preparing state claims for federal Medicaid reimbursement.

[4] Contingency fees generally cannot be claimed for federal Medicaid reimbursement, unless a contingency-fee contract (1) results in cost-avoidance savings or recoveries in which the federal government would share, (2) is competitively procured, and (3) the savings upon which the contingency-fee payment is based are adequately defined and the payments documented to CMS's satisfaction.

[5] Intergovernmental transfers are a tool that state and local governments use to carry out their shared governmental functions, such as collecting and redistributing revenues to provide essential government services.

[6] See related GAO products at the end of this statement.

[7] GAO, *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, GAO-05-748 (Washington, D.C.: June 28, 2005).

In summary, for many years we have reported on the varied financing schemes and questionable methods that states have used to increase the federal reimbursements they receive for operating their state Medicaid programs. In our view, these methods can undermine the Medicaid federal-state partnership and threaten the fiscal integrity of the program. We previously reported that:

- Some states have used IGTs to make large supplemental payments to government-owned or government-operated providers, which have greatly exceeded the established Medicaid payment rates. Such supplemental payments create the illusion of valid expenditures for services delivered to Medicaid beneficiaries and allow states to obtain the federal reimbursement, only to have the local government providers, under agreements with the states, transfer the excessive federal and state payments back to the state. As a result, some states are able to shift a portion of their share of program expenditures to the federal government, essentially increasing the federal matching rate beyond that established under federal law.
- Some states and school districts have used questionable methods to increase federal Medicaid reimbursement for Medicaid health services and administrative costs, that is, methods that lacked sufficient controls to ensure that the claims were legitimate. Medicaid funding is available for certain health services provided by local school districts, such as diagnostic screening and physical therapy for eligible children, including those with disabilities. Medicaid reimbursement is also available for the administrative costs of providing school-based Medicaid services. We found funding arrangements in some states among schools, states, and private consulting firms that resulted in schools' receiving a small portion

of the Medicaid reimbursements, while some states retained up to 85 percent of Medicaid reimbursements for school-based health services or administrative claims. Moreover, some school districts paid contingency fees to the private consultants who assisted them in preparing and submitting Medicaid claims, further reducing the net amount the schools received.

As we are reporting today, a growing number of states are using consultants on a contingency-fee basis to maximize federal Medicaid reimbursements. As of 2004, 34 states—up from 10 states in 2002—used contingency-fee consultants for this purpose. We identified some claims from contingency-fee projects that appear to be inconsistent with current CMS policy and some that were inconsistent with federal law; we also found claims that undermined the fiscal integrity of the Medicaid program. In Georgia and Massachusetts, where we focused our review of specific projects, selected projects that involved the assistance of contingency-fee consultants generated a significant amount of additional federal reimbursements for the states: from fiscal year 2000 through 2004, an estimated $1.5 billion for Georgia and nearly $570 million for Massachusetts. For those additional reimbursements, Georgia paid its consultant about $82 million in contingency fees, and Massachusetts paid its consultants about $11 million in contingency fees. Just to be clear: any state's use of consultants—including contingency-fee consultants—or any associated growth in federal reimbursements, is not problematic, in and of itself. However, we identified concerns in each of the five categories of claims where we reviewed the states' contingency-fee projects: supplemental payment arrangements, school-based services, targeted case management, rehabilitation services, and administrative costs, in either Georgia, Massachusetts, or both states. We found that problematic projects often tended to be in areas of Medicaid claims where federal requirements were inconsistently applied, evolving, or not specific. The lack of clear CMS guidance has allowed states to develop new financing arrangements, or to continue existing ones, that take advantage of ambiguity and result in considerable additional costs to the federal government.

We believe that the continuing problems we have reported in several high-risk categories of Medicaid claims illustrate not only the need to improve oversight of claims stemming from contingency-fee projects, but also the urgent need for CMS to address certain issues in its overall financial management and oversight of Medicaid. In our report issued today, we are reiterating certain recommendations we have previously made to Congress and to the Administrator of CMS that remain open, as well as new ones to the Administrator to improve the financial management and oversight, and fiscal integrity, of the Medicaid program.

In commenting on a draft of the report issued today, CMS stated that it has already substantially met our recommendations. While acknowledging that improper Medicaid payments had unquestionably occurred, the agency provided detailed information to support why it believes that it (1) was already aware of the concerns identified in projects we examined and (2) has taken sufficient action to address these concerns and our related GAO recommendations. In our view, however, CMS has not sufficiently identified or addressed the concerns that we identified, and we believe CMS needs to do more to identify problematic claims resulting from contingency-fee projects sooner, before large reimbursements have been made to states. We continue to believe that CMS needs to do more to clarify, communicate, and consistently apply its policies concerning certain high-risk areas of the Medicaid program.

Background

Title XIX of the Social Security Act[8] authorizes federal funding to states for Medicaid, which finances health care for certain low-income children, families, and individuals who are aged or disabled. Although states have considerable flexibility in designing and operating their Medicaid programs, they must comply with federal requirements specified in Medicaid statute and regulation. For example, states must provide methods to ensure that payments for services are consistent with economy, efficiency, and quality of care.[9] Medicaid is an entitlement program: states are generally obligated to pay for covered services provided to eligible individuals, and the federal government is obligated to pay its share of a state's expenditures under a CMS-approved state Medicaid plan.

Our prior and current work addresses five categories of Medicaid claims where we are aware that states have reimbursement-maximizing strategies. Our current work in particular concentrated on these five categories because—on the basis of factors such as nationwide growth in dollars claimed, the results of our past reviews, and work by HHS's Office of Inspector General (OIG) to assess the appropriateness of claims in these categories—we judged them to be of particularly high risk. Over the past few years, states' claims in some of these categories have grown significantly in dollar amounts. The five categories of claims we examined, and recent trends in claimed expenditures, are described in table 1.

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[8] 42 U.S.C. §§ 1396, et seq. (2000).

[9] 42 U.S.C. § 1396a(a)(30) (2000).

Table 1: Five Categories of Medicaid Claims Reviewed by GAO Where States Are Maximizing Federal Medicaid Reimbursements and Trends in Reported Expenditures

Category of Medicaid claims	Trends in reported expenditures
Supplemental payment arrangements: A common supplemental payment arrangement is known as the upper payment limit, or UPL, arrangement. UPL is the upper bound on what the federal government will pay as its share of Medicaid costs; it is the federal government's way of placing a ceiling on federal financial participation in a state's Medicaid program. UPLs are tied to the methodology that Medicare, the federal health care program that covers seniors aged 65 and older and some disabled persons, uses to pay for comparable services. The rates that states pay their Medicaid service providers are often lower than the federal Medicare rates to which Medicaid UPL rates are tied. Thus, a gap often exists between the amount states actually spend to provide services to Medicaid beneficiaries and the Medicare-based UPLs. States can obtain additional federal funding for the amount under the UPL ceiling by making supplemental payments to a class of providers, such as nursing homes or hospitals.	Federal and state UPL expenditures through all UPL arrangements grew from an estimated $10.3 billion in 28 states in fiscal year 2000 to $11.2 billion in 45 states in fiscal year 2004. During this time period, Congress and CMS acted to limit excessive UPL arrangements and associated claims.[a]
School-based services: Schools can help identify Medicaid-eligible low-income children, facilitate their enrollment in Medicaid, and provide them certain Medicaid-covered services. When Medicaid-eligible children receive Medicaid services—such as diagnostic screening or physical therapy—through the school system, states can use their Medicaid programs to pay for these services. School districts may also receive Medicaid reimbursement for the administrative costs of providing school-based Medicaid services.	For fiscal years 2002 through 2003, combined federal and state spending on school-based services grew 8 percent nationwide, from $1.97 billion to $2.13 billion. Nationwide, more than $900 million (federal and state) went toward school-based administrative costs in both fiscal years 2002 and 2003.
Targeted case management services (TCM): Case management helps beneficiaries gain access to needed medical, social, educational, and other services and coordinates beneficiaries' use of providers. TCM enables states to provide case management services to a defined group or groups of Medicaid-eligible individuals without providing the same service to all Medicaid beneficiaries statewide, as normally required by Medicaid law. Current CMS policy does not allow federal Medicaid reimbursement for TCM services provided by the state if those services are "an integral component" of an existing state program.[b]	For fiscal years 1999 through 2003, combined federal and state spending for Medicaid TCM services increased by 76 percent, from $1.7 billion to $3 billion.
Rehabilitation services: Rehabilitation services are intended for the maximum reduction of a physical or mental disability and to restore an individual to the best possible functional level. Covered services may include occupational and physical therapy, mental health services, and treatment for addiction. The benefit is optional, that is, state Medicaid programs are not required to cover the service but may do so at their own option.	Because rehabilitation services are not reported separately in CMS expenditure reports, the trend in expenditures for these services is unknown.
Administrative costs: The federal government reimburses states, generally at 50 percent, for their costs of administering their Medicaid programs. To determine which administrative costs the state can attribute to Medicaid, states submit a cost allocation plan for HHS approval.[c] This plan establishes the methods the state will use to distribute its administrative costs—such as employee time and costs related to providing services to both Medicaid-eligible and non-Medicaid-eligible individuals—across different funding sources.	For fiscal years 1999 through 2003, combined federal and state spending for the states' Medicaid administrative costs grew 37 percent, from $9.5 billion to $13.0 billion.[d]

Source: GAO.

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[a] For example, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 directed CMS to issue a final regulation to limit states' ability to claim excessive federal reimbursements through UPL supplemental payments.

[b] CMS recently reiterated this policy in a 2004 Administrator's decision that denied approval of a state plan amendment requested by Maryland to provide TCM services to children in the state's foster care program. See ~~CMS, *Disapproval of Maryland State Plan Amendment No. 02-05,* Docket No.~~ 2003-02 (Aug. 27, 2004). The Administrator's decision was based in part on a statement in the legislative history accompanying the legislation authorizing coverage for TCM services that payment for TCM services must not duplicate payments to public agencies or private entities under other program authorities. See H.R. Rep. No. 99-453, at 546 (1985). We did not evaluate the legal basis for CMS's policy as part of this review.

[c] Unlike CMS's direct review and approval role for states' Medicaid plan amendments, CMS has an advisory review role for the plans that state Medicaid agencies prepare for allocating their administrative overhead costs; at the national level, HHS's Division of Cost Allocation instead takes the lead in reviewing these cost allocation plans. The division generally distributes copies of cost allocation plan sections to affected federal agencies, including CMS, for comment.

[d] These figures include costs associated with school-based administration.

States Have Used Intergovernmental Transfers to Facilitate Financing Schemes That Inappropriately Increase Federal Medicaid Reimbursements

For many years, states have used varied financing schemes, sometimes involving IGTs, to inappropriately increase federal Medicaid reimbursements. Some states, for example, have made large Medicaid payments to certain providers, such as nursing homes operated by local governments, which have greatly exceeded the established Medicaid payment rate. These transactions create the illusion of valid expenditures for services delivered by local-government providers to Medicaid-eligible individuals and enable states to claim large federal reimbursements. In reality, the spending is often only temporary because states require the local governments to return all or most of the money to the states through IGTs. Once states receive the returned funds, they can use them to supplant the states' own share of future Medicaid spending or even for non-Medicaid purposes.

As various schemes involving IGTs have come to light, Congress and CMS have taken actions to curtail them, but as one approach has been restricted, others have often emerged. Table 2 describes some of the states' financing schemes over the years and how Congress and CMS have responded to them.

Table 2: Medicaid Financing Schemes Used to Inappropriately Generate Federal Reimbursements and Federal Actions to Address Them

Financing arrangement	Description	Action taken
Excessive payments to state health facilities	States made excessive Medicaid payments to state-owned health facilities, which subsequently returned these funds to the state treasuries.	In 1987, the Health Care Financing Administration (HCFA) issued regulations that established payment limits specifically for inpatient and institutional facilities operated by states.
Provider taxes and donations	Revenues from provider-specific taxes on hospitals and other providers and from provider "donations" were matched with federal funds and paid to the providers. These providers could then return most of the federal payment to the states.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 essentially barred certain provider donations, placed a series of restrictions on provider taxes, and set other restrictions for state contributions.
Excessive disproportionate share hospital (DSH) payments	DSH payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which then returned the bulk of the state and federal funds to the state.	The Omnibus Budget Reconciliation Act of 1993 placed limits on which hospitals could receive DSH payments and capped both the amount of DSH payments states could make and the amount individual hospitals could receive.
Excessive DSH payments to state mental hospitals	A large share of DSH payments were paid to state-operated psychiatric hospitals, where they were used to pay for services not covered by Medicaid or were returned to the state treasuries.	The Balanced Budget Act of 1997 limited the proportion of a state's DSH payments that can be paid to state psychiatric hospitals.
Upper payment limit (UPL) for local-government health facilities	Federal regulations prohibit Medicaid from paying more than a reasonable estimate of the amount that would be paid under Medicare payment principles for comparable services. This UPL applies to payments aggregated across a class of facilities and not for individual facilities. As a result of the aggregate upper limit, states were able to make large supplemental payments to a few local public health facilities, such as hospitals and nursing homes. The local-government health facilities then returned the bulk of the state and federal payments to the states.	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required HCFA to issue a final regulation that established a separate payment limit for each of several classes of local-government health facilities. In 2002, CMS issued a regulation that further lowered the payment limit for local public hospitals.

Source: GAO, *Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes*, GAO-04-574T (Washington, D.C.: Mar. 18, 2004). Before June 2001, CMS was known as the Health Care Financing Administration (HCFA).

A leading variant of these illusory financing arrangements today involves states' taking advantage of Medicaid's upper payment limit (UPL) provisions. Although states are allowed, under law and CMS policy, to claim federal reimbursements for supplemental payments they make to providers up to the UPL ceilings, we have reported earlier that payments in excess of the provider's costs that are not retained by the provider as reimbursement for services actually provided are inconsistent with

Medicaid's federal-state partnership and fiscal integrity.[10] For example, we have reported that by paying nursing homes and hospitals owned by local governments much more than the established Medicaid payment rate and requiring the providers to return, through IGTs, the excess state and federal payments to the state, states obtain excessive federal Medicaid reimbursements while their own state expenditures remain unchanged or even decrease.[11] Such round-trip payment arrangements can be accomplished via electronic wire transfer in less than an hour. States have then used the returned funds to pay their own share of future Medicaid spending or to fund non-Medicaid programs.

Problems with excessive supplemental payment arrangements remain, despite congressional and CMS action to curtail financing schemes. For example, in our current review of states' use of contingency-fee consultants, we found an example in Georgia that illustrates how current law and policy continue to allow states to generate excessive federal reimbursements beyond established Medicaid provider payments for covered services. Georgia and its consultant developed five UPL arrangements using IGTs—one each for local-government-operated inpatient hospitals, outpatient hospitals, nursing homes and for state-owned hospitals and nursing homes. Over the 3-year period of state fiscal years 2001 through 2003, the state made supplemental payments totaling $2.0 billion to nursing homes and hospitals operated by local governments (see fig. 1). A sizable share of the $2.0 billion payments was illusory, however. In reality, the nursing homes and hospitals netted only $357 million because they had initially transferred $1.7 billion to the state Medicaid agency, through IGTs, under an agreement with that agency. The state combined this $1.7 billion with $1.2 billion in federal funds, which represented the estimated federal share of its supplemental payments to local-government facilities of $2.0 billion. The state thus had a funding pool of $2.9 billion at its disposal. From this pool, the state made the $2.0 billion in supplemental payments to local-government providers and retained $844 million to offset its other Medicaid expenditures.

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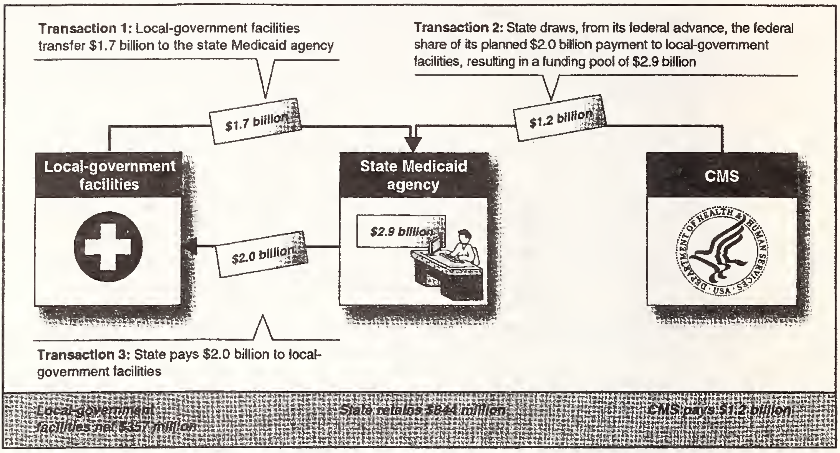
[10] See, for example, GAO-04-574T and *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, GAO-04-228 (Washington, D.C.: Feb. 13, 2004).

[11] In another approach, some states require a few counties to initiate the transaction by taking out bank loans for the total amount the states determined they can pay under the UPL. The counties wire the funds to the states, which then send most or all of the funds back to the counties as Medicaid payments. The counties use these "Medicaid payments" to repay the bank loans. Meanwhile, the states claim federal matching funds on the total amount.

Figure 1: Georgia's UPL Arrangement with Local-Government Health Care Providers, State Fiscal Years 2001–2003



Transaction 1: Local-government facilities transfer $1.7 billion to the state Medicaid agency

Transaction 2: State draws, from its federal advance, the federal share of its planned $2.0 billion payment to local-government facilities, resulting in a funding pool of $2.9 billion

Transaction 3: State pays $2.0 billion to local-government facilities

$1.7 billion
$1.2 billion
Local-government facilities
State Medicaid agency
CMS
$2.9 billion
$2.0 billion
Local-government facilities net $357 million
State retains $844 million
CMS pays $1.2 billion

Source: GAO.

Note: Totals may not add up because of rounding. See GAO-05-748.

In our view, the inappropriate use of IGTs in schemes such as UPL financing arrangements violates the fiscal integrity of Medicaid's federal-state partnership in at least three ways.

- The schemes effectively increase the federal matching rate established under federal law by increasing federal expenditures while state contributions remain unchanged or even decrease. We previously estimated that one state effectively increased the federal share of its total Medicaid expenditures from 59 percent to 68 percent in state fiscal year 2001, by obtaining excessive federal funds and using these as the state's share of other Medicaid expenditures.[12]

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[12] GAO-04-228.

- There is no assurance that these increased federal reimbursements are used for Medicaid services, since states use funds returned to them via these schemes at their own discretion. In examining how six states with large schemes used the federal funds they generated, we previously found that one state used the funds to help finance its education programs, and others deposited the funds into state general funds or other special state accounts that could be used for non-Medicaid purposes or to supplant the states' share of other Medicaid expenditures.[13]
- The schemes enable states to pay a few public providers amounts that well exceed the costs of services provided, which is inconsistent with the statutory requirement that states provide for methods that ensure that Medicaid payments are consistent with economy and efficiency. We previously reported that, in one state, the state's proposed scheme increased the daily federal payment per Medicaid resident from $53 to $670 in six local-government-operated nursing homes.[14]

Questionable Methods Have Boosted Federal Reimbursements for School-Based Claims

Another category of claims where states have used questionable practices to maximize federal reimbursements is services provided to children in schools and associated administrative costs. Medicaid is authorized to cover services to, for example, Medicaid-eligible children with disabilities who may need diagnostic, preventive, and rehabilitative services; speech, physical and occupational therapies; and transportation. School districts may also receive Medicaid reimbursement for the administrative costs of providing school-based Medicaid services. Our work in this area has addressed claims for Medicaid school-based health services and administration. In 1999, we found a need for federal oversight of growing Medicaid reimbursements to states for Medicaid school-based administrative services, including outreach activities to enroll children in Medicaid.[15] In April 2000, we reported that Medicaid expenditures for school-based health services totaled about $1.6 billion for services provided by schools in 45 states and the District of Columbia, while Medicaid administrative expenditures were about $712 million for costs billed by schools in 17 states.[16] We found that some of the methods used by school districts and states to claim reimbursement for school-based health services did not ensure that the services paid for were provided: some claims, for example, were made solely on the basis of at least one day's attendance in school, rather than on documentation of any actual service delivery. Methods used by school districts to claim Medicaid reimbursement failed in some cases to take into account variations in service needs among children.

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[13] GAO-04-228.

[14] GAO, *Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes,* GAO-02-147 (Washington, D.C.: Oct. 30, 2001).

[15] GAO, *Medicaid: Questionable Practices Boost Federal Payments for School-Based Services,* GAO/T-HEHS-99-148 (Washington, D.C.: June 17, 1999).

With regard to Medicaid school-based administrative costs, we found that some methods used by school districts and states did not ensure that administrative activities were properly identified and reimbursed. Poor controls resulted in improper payments in at least two states, and there were indications that improprieties could have been occurring in several other states. We further found that, in some states, funding arrangements among schools, states, and private consulting firms created adverse incentives for program oversight and caused schools to receive a small portion—as little as $7.50 for every $100 in Medicaid claims—of Medicaid reimbursement for school-based administrative and service claims. We reported that 18 states retained a total of $324 million, or 34 percent, of federal funds intended to reimburse schools for their Medicaid administrative and service claims; for 7 of the states, this amounted to 50 to 85 percent of federal Medicaid reimbursement for school-based health services claims. In addition, contingency fees, which some school districts paid to private consultants for their assistance in preparing and submitting Medicaid claims, ranged from 3 to 25 percent of the federal reimbursement, further reducing the net amount that schools received.

In response to recommendations we made to the Administrator of CMS, CMS has clarified guidance for states on submitting claims for school-based administrative activities.[17] Subsequent to our work, HHS OIG conducted reviews of school-based claims in 18 states from November

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[16] GAO, *Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight,* GAO/HEHS/OSI-00-69 (Washington, D.C.: Apr. 5, 2000). States were asked to provide school-based claims data for the most recent fiscal year for which they were available, which for approximately half the states was state fiscal year 1999. Most of the remaining states provided data for state fiscal year 1998, federal fiscal year 1998, or calendar year 1998; three states provided data for periods before July 1997.

[17] CMS, *Medicaid School-Based Administrative Claiming Guide* (May 2003).

2001 through June 2005, several of which have identified issues with the appropriateness of claims related to consultants' projects.[18]

In our own most recent work, we determined that Georgia was retaining a share of the additional federal reimbursements gained from its claims for Medicaid school-based services. Georgia's contingency-fee consultant assisted the state with its Medicaid claims for school-based services in a project that generated about $54 million in federal Medicaid reimbursements over the 3 years the consultant was paid and that, on the basis of state data, we estimate continues to generate about $25 million annually.[19] As before, we found that the school districts were not receiving all of the federal Medicaid reimbursements that were generated on their behalf. According to a state official and documents provided by the state, the state retained $3.9 million, or 16 percent, of federal reimbursements that were claimed on behalf of the school districts for state fiscal year 2003, most of which was used to pay its contingency-fee consultant and about $1 million of which was used to cover the salaries and administrative costs of the five state employees who administered school-based claims in Georgia.[20]

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[18] See, for example, HHS OIG, *Medicaid Payments for School-Based Health Services—Massachusetts Division of Medical Assistance*, A-01-02-00009 (Washington, D.C.: July 14, 2003); and HHS OIG, *Medicaid School-Based Health Services Administrative Costs—Massachusetts*, A-01-02-00016 (Washington, D.C.: Sept. 15, 2004). See GAO-05-748, app. II, for other HHS OIG reports on school-based services and administration.

[19] We did not assess whether the school-based health services that the state claimed were allowable.

[20] GAO-05-748.

States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight

A growing number of states are using consultants on a contingency-fee basis to maximize federal Medicaid reimbursements. CMS reported that, according to a survey it conducted in 2004, 34 states had used consultants on a contingency-fee basis for this purpose, an increase from 10 states reported to have such arrangements in 2002. In the 2 states where we examined selected projects that involved the assistance of contingency-fee consultants, Georgia and Massachusetts, we found that the projects generated a significant amount of additional federal reimbursements for the states: from fiscal year 2000 through 2004, an estimated $1.5 billion in Georgia and nearly $570 million in Massachusetts. For those additional reimbursements, Georgia paid its consultant about $82 million in contingency fees, and Massachusetts paid its consultants about $11 million in contingency fees. We identified claims from contingency-fee consultant projects that appear to be inconsistent with current CMS policy and claims that are inconsistent with federal law; we also identified claims from projects that undermine Medicaid's fiscal integrity. Such projects and resulting problematic claims arose in each of the five categories of claims that we reviewed in Georgia, Massachusetts, or for some categories, both states. We observed two factors common to many projects that we believe increase their risk. First, many projects were in categories of Medicaid claims where federal requirements for the services have been inconsistently applied, are evolving, or were not specific. Second, many projects involved states' shifting costs to the federal government through Medicaid reimbursements to other state or local-government entities.

Some Contingency-Fee Projects in Georgia and Massachusetts Resulted in Problematic Federal Reimbursements

For the five categories of claims we reviewed where states frequently used contingency-fee consultants to maximize their federal Medicaid reimbursements, we identified problematic claims in each category in either Georgia or Massachusetts or in both states. These projects resulted in claims that appear to be inconsistent with current CMS policy and that, for one project, were inconsistent with federal law. We also identified claims that were inconsistent with the fiscal integrity of the Medicaid program. I have already discussed our current findings regarding Georgia's use of IGTs in UPL supplemental payment arrangements and its project to increase claims for school-based Medicaid services and administrative costs. We also reviewed Georgia's and Massachusetts's use of contingency-fee consultants to increase federal reimbursements for targeted case management services, rehabilitation services for mental or physical disabilities, and states' claims for administering their Medicaid programs. In these two states, our findings were most significant in the areas of targeted case management and rehabilitation services.

Targeted Case Management

Georgia and Massachusetts—with the help of their contingency-fee consultants—developed approaches to maximize federal Medicaid reimbursements by claiming costs for targeted case management (TCM) services under state plan amendments that CMS had approved prior to 2002. Georgia's consultant assisted the state in increasing federal Medicaid reimbursement for TCM services provided by two state agencies: the Department of Juvenile Justice and the Division of Family and Children's Services.[21] In Massachusetts, contingency-fee consultants helped the state increase federal reimbursement for TCM services provided by three state agencies: the Departments of Social Services, Youth Services, and Mental Health. These case management services in Georgia and Massachusetts appear integral to the states' own programs; the states' laws, regulations, or policies called for case management services in these programs, and the case management services were provided to all Medicaid- and non-Medicaid-eligible children served by the programs.[22] More recently, CMS has denied coverage for comparable services by other states because CMS determined that the services are an integral component of the state programs providing the services. For example, in fiscal year 2002, CMS denied a state plan amendment proposal to cover TCM services in Illinois and in fiscal year 2004 it found TCM claims in Texas unallowable, in part because the TCM services claimed for reimbursement were considered integral to other state programs. As in Georgia and Massachusetts, the TCM services in Illinois were for children served by the state's juvenile justice system. In Texas, such children were served by the state's child welfare and foster care system.

In fiscal year 2003, we estimate that Georgia received $17 million in federal reimbursements for claims for TCM services provided by its two state agencies, of which about $12 million was for services that appear to be integral to non-Medicaid programs. In fiscal year 2004, Massachusetts received an estimated $68 million in federal reimbursements for services that appear to be integral to non-Medicaid programs in the three state agencies whose TCM projects were developed by consultants.[23] CMS officials agreed with our assessment that the claims for TCM services in these two states were problematic.

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[21] The consultant assisted Georgia by streamlining the billing process, drafting state plan amendment proposals, and increasing the number of Medicaid beneficiaries for whom these two non-Medicaid state agencies billed case management services, thus reducing costs to the state for operating these agencies.

[22] For example, all children served by Georgia's and Massachusetts's child welfare agencies receive a broad range of services to promote their welfare and protect them from abuse and neglect. To fulfill this responsibility, state employees provide case management services, refer the children to others for services, and monitor their well-being and progress.

Rehabilitation Services

Our review of projects involving rehabilitation services found concerns with methods and claims in Georgia. Georgia's consultant helped the state increase federal Medicaid reimbursements for rehabilitation services provided through two state agencies by $58 million during state fiscal years 2001 through 2003. The consultant suggested that state agencies—which pay private facilities under a per diem rate for providing room and board, rehabilitation counseling and therapy, educational, and other services to children in state custody—base their claims for Medicaid reimbursement on the private facilities' estimated costs, instead of on what the state agencies actually paid those facilities. The state agencies increased their claims for Medicaid reimbursement without increasing their payments to the facilities. In some cases, the state agencies' Medicaid claims for rehabilitation services alone exceeded the amount paid by the agencies for all the services the facilities provided to children. Specifically, for 82 of the residential facilities (about 43 percent), the amount the state Medicaid agency reimbursed the two agencies in state fiscal year 2004 exceeded the total amount these agencies actually paid the residential facilities for all services, not just rehabilitation services. One facility, for example, was paid by the Division of Family and Children's Services $37 per day per eligible child for all services covered by the per diem payment, but the state agency billed the Medicaid program $62 per day for rehabilitation services alone. CMS officials agreed with our conclusion that claims from this contingency-fee project were not in accord with the statutory requirement that payments be efficient and economical.

Two Factors Increase Risk of Problematic Claims

During our work we observed two factors that appear to increase the risk of problematic claims. One factor involved federal requirements that were inconsistently applied, evolving, or not specific; the second involved states' claiming Medicaid reimbursement for services provided by other state or local-government agencies. Despite CMS's long-standing concern about state financing arrangements for both TCM and supplemental payments, for example, the agency has not issued adequate guidance to clarify expenditures allowable for federal reimbursement. Federal TCM and supplemental payment policy for allowable claims in these categories has evolved over time, and the criteria that CMS applies to determine whether claims are allowable have been communicated to states primarily through state-specific state plan amendment reviews or claims disallowances, rather than through formal guidance or regulation.

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[23] In examining CMS expenditure reports, we found that both Georgia and Massachusetts had categorized non-TCM services, such as rehabilitation services, as TCM. We obtained estimates from the states of the amount the states had claimed for TCM services.

- **Inconsistently applied policy for allowable TCM services.** In 2002, CMS began to deny proposed state plan amendments that sought approval for Medicaid coverage of TCM services that were the responsibility of other state agencies. CMS had determined that such arrangements were not eligible for federal Medicaid reimbursement for several reasons: (1) the services were typically integral to existing state programs, (2) the services were provided to beneficiaries at no charge, and (3) beneficiaries' choice of providers was improperly limited.[24] However, CMS approved Georgia's and Massachusetts's state plan amendments for TCM services before 2002. Although CMS has been applying these criteria to deny new TCM arrangements—for example, in Maryland, Illinois, and Texas—it has not yet sought to address similar, previously approved TCM arrangements that are inconsistent with these criteria. CMS regional officials told us they could not reconsider the TCM claims from two agencies in Georgia and four in Massachusetts because they were waiting for new guidance that the agency was preparing.[25] CMS has been working on new TCM guidance for more than 2 years, according to agency officials. As of May 2005, however, this guidance had not been issued. CMS's fiscal year 2006 budget submission identifies savings that could be achieved by clarifying allowable TCM services, but CMS had not published a specific proposal at the time we completed our work.[26]

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[24] CMS most recently explained its policy and rationale in a September 2004 Administrator's decision denying a proposed state plan amendment from Maryland to cover TCM services. This decision articulated the criteria that CMS has applied to deny state TCM plan amendments.

[25] A CMS official stated that the agency's most recent guidance on TCM, issued in January 2001, contained problems and errors that caused confusion regarding appropriate TCM claims when non-Medicaid state agencies were involved.

[26] The CMS Administrator's performance budget for fiscal year 2006 proposes to clarify allowable TCM services and align federal reimbursement for TCM services with an administrative matching rate of 50 percent. CMS estimates 5-year budget savings from reducing the reimbursement for TCM to the administrative matching rate of $1 billion.

- **Evolving policy for allowable supplemental payment arrangements.** For several years, we and others have reported on state financing schemes that allow states to inappropriately generate federal Medicaid reimbursement without the state's paying its full share. Although Congress and CMS have taken steps to curb these abuses, states can still develop arrangements enabling them to make illusory payments to gain federal reimbursements for their own purposes. Recognizing that states can unduly gain from supplemental payment arrangements, such as UPL payment arrangements that use IGTs, since fiscal year 2003 CMS has worked with individual states to address such arrangements. At the same time, the agency has not issued guidance stating its policy on acceptable approaches for UPL payment arrangements, specifically the use of IGTs and the relationship to state share of spending. CMS's budget for fiscal year 2006 proposes to achieve federal Medicaid savings by curbing financing arrangements that have been used by a number of states to inappropriately obtain federal reimbursements. The specific proposal, however, had not been published at the time we completed our review.[27]

- **Unspecified policy on allowable Medicaid rehabilitation payments to other state agencies.** CMS has not issued policy guidance that addresses situations where Medicaid payments are made by a state's Medicaid agency to other state agencies for rehabilitation services. CMS financial management officials told us that states' claims for rehabilitation services posed an increasing concern, in part because officials believed that states were inappropriately filing claims for services that were the responsibility of other state programs. CMS does not specify whether claims for the cost of rehabilitation services that are the responsibility of non-Medicaid state agencies are allowable. CMS's fiscal year 2006 budget submission identifies savings that could be achieved by clarifying appropriate methods for claiming rehabilitation services. CMS had not published a specific proposal at the time we completed our review.[28]

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[27] The budget proposes to build on CMS's efforts to curb questionable financing practices by (1) recovering federal funds claimed for covered services but retained by the state and (2) capping payments to government providers at no more than the cost of furnishing services to Medicaid beneficiaries. CMS estimated 5-year budget savings of $5.9 billion from this proposal. CMS's proposal is consistent with a recommendation that we first made to Congress in 1994 to consider legislation to prohibit Medicaid payments to government providers that exceed the providers' actual costs. See *GAO, Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government,* GAO/HEHS-94-133 (Washington, D.C.: Aug. 1, 1994).

The second factor we observed that increased the financial risk to the federal government of reimbursement-maximizing projects was that the projects shifted state costs to the federal government by claiming Medicaid reimbursement for services provided by other non-Medicaid state or local government agencies. Medicaid reimbursement to government agencies serving Medicaid beneficiaries is allowable in cases where the claims apply to covered services and the amounts paid are consistent with economy and efficiency. However, the projects and associated claims we reviewed showed that reimbursement-maximizing projects often involved services and circumstances that Medicaid should not pay for—such as illusory payments to government providers.

Problems Illustrate Need to Improve the Financial Management of Medicaid

As we describe in the report issued today, the problems we identified with states' Medicaid claims stemming from contingency-fee projects illustrate the urgent need to address certain issues in CMS's overall financial management of the Medicaid program. These issues, however, are not limited to situations that involve contingency-fee consultants. We have identified problems with claims in states other than Georgia and Massachusetts that have undertaken reimbursement-maximizing activities, without employing consultants, in categories of long-standing concern, such as supplemental payment arrangements. CMS relies on its standard financial management controls to identify any unallowable Medicaid claims that states may submit, including those that might be associated with reimbursement-maximizing contingency-fee projects. However, CMS lacks clear, consistent policies to guide the states' and its own financial oversight activities. Furthermore, in our previous work on CMS's financial management, we found that the agency did not have a strategy for focusing its resources most effectively on areas of high risk.[29] In our current work, we found that CMS has known for some time that two high-risk categories we identified—claims generated from consultants paid on a contingency-fee basis to maximize reimbursements and claims generated from arrangements where state Medicaid programs are paying other state agencies or government providers—were problematic. For example, CMS had listed these two categories on a financial tracking sheet of high-risk areas as of 2000.[30] At an October 2003 congressional hearing, the CMS Administrator expressed concern that the Medicaid program was understaffed and that consultants in the states were "way ahead of" CMS in helping states take advantage of the Medicaid system.[31]

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[28] The CMS Administrator's budget for fiscal year 2006 expresses CMS's concern that states have attempted to shift costs associated with other social service programs to Medicaid. The budget proposes to clarify allowable services that could be claimed as rehabilitation. For its proposal to clarify allowable TCM and rehabilitation services that could be claimed, CMS estimates 5-year budget savings of $2 billion. See Centers for Medicare & Medicaid Services' performance budget proposal for fiscal year 2006.

CMS has undertaken important steps to improve its financial management of the Medicaid program. A major component of the agency's initiative is hiring, training, and deploying approximately 100 new financial analysts, mainly to regional offices. These analysts are responsible for identifying state sources of Medicaid funding and contributing to the review of state budget estimates and expenditure reports. Expectations for CMS's new Division of Reimbursement and State Financing and for the 100 new financial analysts are high and their responsibilities broad. It is too soon, however, to assess their accomplishments.

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[29] See, for example, GAO, *Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed,* GAO-02-300 (Washington, D.C.: Feb. 28, 2002). This February 2002 report found that CMS's systems for financial oversight of state Medicaid programs were limited. We recommended a range of approaches to strengthen internal controls and target limited resources, including that CMS revise its existing risk-assessment efforts to more effectively and efficiently target oversight resources to areas most vulnerable to improper payments. An ongoing GAO review is assessing CMS's progress in implementing related recommendations. Also, in a report on state financing schemes (see GAO-04-228), we recommended that CMS improve oversight of state UPL projects, including issuing guidance to states setting forth acceptable methods to calculate UPLs. These recommendations remain open.

[30] In 2001, CMS asked each regional office to complete a risk assessment to identify the extent to which states in each region have attributes warranting closer CMS financial oversight and scrutiny. The identified risk factors that regional staff were asked to assess included: areas where federal policy was unclear, states' use of a contingency-fee consultant to maximize reimbursements, and payments to public providers in which state Medicaid agencies may lack an incentive to monitor and control expenditures. Regional officials were to base their assessment of these and other risk factors on their working knowledge of each state.

[31] Thomas Scully, Administrator, Centers for Medicare & Medicaid Services, responding to questions at a hearing, *Challenges Facing the Medicaid Program in the 21st Century: Hearing before the Subcommittee on Health, House Committee on Energy and Commerce,* 108th Cong., 1st Sess., October 8, 2003.

Conclusions

For more than a decade, we and others have reported on the methods states have used to inappropriately maximize federal Medicaid reimbursement and have made recommendations to end financing schemes. CMS has taken important steps in recent years to improve its financial management. Yet more can be done.

Many of the problematic methods we examined involved categories of claims where CMS policy has been inconsistently applied, evolving, or unspecified. They have also involved increasing payments to units of state and local government—which states have long used to maximize federal Medicaid funding, in part because IGTs can help facilitate illusory payments—suggesting that greater CMS attention is needed to payments among levels of government, regardless of whether consultants are involved. We believe that it is important to act promptly to curb opportunistic financing schemes before they become a staple of state financing and further erode the integrity of the federal-state Medicaid partnership. Addressing recommendations that remain open from our prior work on state financing schemes and on CMS's financial management could help resolve some of these issues. In addition, in the report being issued today, we are making new recommendations to the Administrator of CMS to improve the agency's oversight of states' use of contingency-fee consultants and to strengthen certain of the agency's overall financial management procedures. These recommendations address developing guidance to clarify CMS policy on TCM, supplemental payment arrangements, rehabilitation services, and Medicaid administrative costs; ensuring that such guidance is applied consistently among states; and collecting and scrutinizing information from states about payments made to units of state and local governments.

Understandably, states that have relied on certain practices to increase federal funds as a staple for the state share of Medicaid spending are concerned about the potential loss of these funds. The continuing challenge remains to find the proper balance between states' flexibility to administer their Medicaid programs and the shared federal-state fiduciary responsibility to manage program finances efficiently and economically in a way that ensures the fiscal integrity of the program. States should not be held solely responsible for developing arrangements that inappropriately maximize federal reimbursements where policies have not been clear or clearly communicated or where CMS has known of risks for some time and has not acted to mitigate them. Without clear and consistent communication of policies regarding allowable claims in high-risk areas, such as those for TCM and UPL where billions of dollars are claimed each year, CMS is at risk of treating states inconsistently and of placing undue burdens on states to understand federal policy and comply with it.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Committee may have.

Contact and Acknowledgments

For future contacts regarding this testimony, please call Kathryn G. Allen at (202) 512-7118. Katherine Iritani, Ellen M. Smith, Helen Desaulniers, and Kevin Milne also made key contributions to this testimony.

RESPONSES OF KATHRYN G. ALLEN, GAO, TO QUESTIONS OF THE COMMITTEE ON FINANCE, U.S. SENATE

PURSUANT TO THE JUNE 28TH, 2005 COMMITTEE HEARING ON MEDICAID WASTE, FRAUD AND ABUSE: THREATENING THE HEALTH CARE SAFETY NET

Questions from Senator Grassley

(1) Testimony at the hearing provided a number of different mechanisms that States use to increase their Federal share of Medicaid funding. One such mechanism is the use of the Federal Upper Payment Limit (UPL) to shift costs to the Federal government. Could you please explain why previous actions of Congress and CMS to curtail inappropriate financing schemes have not eliminated states' ability to shift costs to the Federal government and what Congress can do to fix this problem?

GAO Response

Congress and CMS have taken steps to curb state financing mechanisms which use UPL and other arrangements to shift costs to the Federal government, and these steps have saved the federal government billions of dollars to date.[1] These steps have narrowed the UPL loophole, but have not closed it altogether. Our work has demonstrated that some states continue to benefit from financing schemes that involve drawing down federal Medicaid reimbursements for payments they have made to government providers, such as local governments who operate nursing facilities, that substantially exceed costs. States can do so by taking advantage of the "gap" between their Medicaid payment rates and the UPL, and making illusory payments to government providers who ultimately do not retain the excessive payments. Because there continue to be large differences between state Medicaid payment rates and the UPL—the upper bound on what the federal government will pay tied to the amount Medicare pays for comparable services—we believe the Congress should consider limiting Medicaid payments to government providers' costs.

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[1] The state schemes that involve excessive federal payments have been restricted by (1) the Omnibus Budget Reconciliation Act of 1993 that limits disproportionate share payments to unreimbursed Medicaid and uninsured costs for state-owned facilities (Pub. L. No. 103-66, § 13621(b), 107 Stat. 312, 630-632), (2) the Balanced Budget Act of 1997 that further limits such Medicaid payments to psychiatric hospitals (Pub. L. No. 105-33, § 4721(b), 111 Stat. 251, 513-514), and (3) the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. No. 106-554, App. F, § 705(a), 114 Stat. 2763A-463, 575-576), which directed the Health Care Financing Administration (now called CMS) to issue a final regulation that curtailed states' ability to claim excessive federal matching funds through UPL financing schemes, which CMS did in January 2001 (*see* 42 C.F.R. Part 447 (2002)). The January 2001 regulation narrowed the UPL loophole by establishing separate UPLs for private, state, and local-government facilities. Prior to this regulation, states were allowed to make claims for excessive payments of aggregate UPL amounts for all private and local-government facilities, which could return the excessive payment to the state through an intergovernmental transfer with the governmental units. The Congressional Budget Office estimated that the BIPA legislation curtailing states' use of the UPL loophole would result in federal budget savings of about $21.5 billion for the first five years of implementation.

(2) While the Committee heard much regarding the problems of Medicaid as well as proposed solutions, there was little discussion on the realities of doing so, mainly a possible transition period. Cutting off funding that states receive as a result of these revenue maximization strategies could adversely impact beneficiaries. Would the use of a transition period help to ease the states away from the use of these improper methods of increase federal funding?

GAO Response

Yes. Some states may have come to rely on excessive federal funds that they received through inappropriate financing mechanisms. Providing for a transition period could help ease states' budget situations on a temporary basis and help to avoid an adverse impact on beneficiaries. We believe that all transition period decisions should be based on clear criteria that are consistently applied among states.

We note that there is precedent for the use of transition periods in this context. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 directed CMS, then called HCFA, to issue a final regulation to limit states' ability to claim excessive federal matching funds through UPL arrangements and required the final regulation to provide for transition periods as long as 8 years, during which time excessive UPL payments would be phased out.[2] We earlier reported, however, that CMS's decision to grant two states an 8-year transition period was not consistent with the purpose the agency identified for the UPL regulation and for transition periods, that is, to address the problems of states with long-standing budgetary reliance on excessive payments. We recommended that CMS establish criteria for making transition periods that are consistent with the objectives of the regulation and reassess its initial decisions.[3]

Questions from Senator Baucus

(1) Your report indicates that states' use of Medicaid consultants may be increasing the likelihood of questionable financing arrangements and possible abuses in Medicaid. However, you also indicate that the use of consultants in Medicaid is now permitted under law. Based on these findings, what are your views on whether federal law should be changed to limit or prohibit their use in the Medicaid program? What specific changes, if any, would you recommend?

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[2] *See* Pub. L. No. 106-554, App. F, § 705, 114 Stat. 2763A-463, 575-577 (2000).

[3] See GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes is Needed*, GAO-04-228 (Washington D.C.: February 13, 2004).

GAO Response

As we recently reported, consultants can have a legitimate role in helping states administer their Medicaid programs, such as adding needed expertise and saving states and the federal government money.[4] Additional information, however, could help CMS improve its oversight of states' Medicaid programs. We recommended that CMS routinely request that states disclose their use of contingency-fee consultants, as a means of improving CMS monitoring of high-risk Medicaid claims, and to seek legislative authority to require disclosure in the event that states do not voluntarily provide this information.

(2) Your report specifically cites the inconsistent application of CMS enforcement policy as playing a role in increasing the risk of problematic state financing claims. Do you think that the incidence of state abuses might be decreased if CMS issued a rule that provided states clear notice of abusive practices?

GAO Response

On the basis of our past and recent work reviewing states' financing schemes and use of contingency-fee contracts to maximize federal reimbursement, we believe additional guidance from CMS is needed to reduce the incidence of problematic claims. We earlier recommended that CMS establish uniform guidance to set forth acceptable methods for calculating states' upper payment limits; however, our recommendation has not been implemented.[5] We have also noted that CMS has not been prompt in stopping new financing schemes as they are identified, in part because CMS has not, as you suggest, clearly informed states that such practices are unallowable. Although we did not assess whether rulemaking would be required, our most recent report on states' use of contingency-fee consultants recommended that CMS establish or clarify and then communicate its policies on allowable claims for targeted case management services, supplemental payment arrangements, rehabilitation services, and Medicaid administrative costs.[6] Once its policies are clarified, CMS should ensure that they are applied consistently across all states.

The results of ongoing GAO work, once completed, will likely help to further respond to this question. We have work ongoing for the Committee on Finance, U.S. Senate, reviewing CMS's current enforcement process for ending states' inappropriate financing methods and the extent to which CMS is consistently applying its criteria and policy through this process.

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[4] See GAO, *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, GAO-05-748 (Washington, D.C.: June 28, 2005).
[5] See GAO-04-228.
[6] See GAO-05-748.

Questions from Senator Rockefeller

Ms. Allen, in July of 2002, GAO released a report entitled "Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns." In that report, GAO questioned "the extent to which HHS has ensured that the approved waivers are consistent with the goals and fiscal integrity of Medicaid and SCHIP." GAO also found that the "opportunity for the public to learn about and comment on pending waivers has not been consistently provided in accordance with policy adopted by HHS in 1994."

(1) Can you talk more specifically about this report and its findings? I am specifically interested in the HHS policy established in 1994, which requires the agency to publish notification of new and pending section 1115 waiver applications in the *Federal Register* with a 30-day comment period and how that policy has been applied to recent waiver applications.

GAO Response

Our July 2002 report on HHS approval of Medicaid and SCHIP demonstration waivers found both legal and policy concerns about the extent to which HHS had ensured that the approved waivers were consistent with the goals and fiscal integrity of Medicaid and SCHIP.[7] We also found that the opportunity for the public to learn about and comment on pending waivers had not been consistently provided in accordance with policy adopted by HHS in 1994. HHS's policy had been to publish notification of new and pending demonstration waiver applications in the *Federal Register* with a 30-day comment period. We found at that time that HHS had not published a waiver application for review and public comment since 1998. An HHS official said the current agency policy did not include public notice and comment because the states are considered to be a more appropriate forum for public input. But we found that state-level activities varied widely, and did not necessarily guarantee consensus on a state's planned waiver and that HHS's review process raised additional concerns by reducing the information states must provide on the extent of their public process. We recommended that the Secretary of HHS provide for a federal public input process that includes, at a minimum, notice of pending demonstration waiver proposals in the *Federal Register* and a 30-day comment period in line with HHS's 1994 policy. HHS disagreed with the need to implement this and other recommendations we made to ensure the appropriate spending of SCHIP funds and to improve the waiver review and approval process; consequently, we raised two of our recommendations to HHS to the attention of Congress for consideration.

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[7] *See* GAO, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns,* GAO-02-817 (Washington, D.C.: July 12, 2002). Our legal concern was that HHS had allowed a state to use unspent SCHIP funding to cover adults without children, despite SCHIP's statutory objective of expanding health coverage to low-income children. In our view, HHS's approval was not consistent with the SCHIP objective, and was not authorized. Despite our report, HHS has since approved at least three additional waivers of this type (see GAO, *SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals,* GAO-04-166R, Washington D.C.: January 5, 2004). One policy concern addressed in our 2002 report was that HHS had not ensured that approved demonstration projects would be budget neutral, that is, that the federal government would not spend more under the waivers than it would have had the waivers not been approved.

(2) Has CMS undertaken measures to remedy the problems mentioned in the report to GAO's satisfaction?

GAO Response

No, CMS has not implemented our report's recommendations.

United States Government Accountability Office

GAO

Testimony
Before the Committee on Finance,
U.S. Senate

For Release on Delivery
Expected at 10:00 a.m. EDT
Tuesday, June 28, 2005

MEDICAID FRAUD AND ABUSE

CMS's Commitment to Helping States Safeguard Program Dollars Is Limited

Statement of Leslie G. Aronovitz
Director, Health Care

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Highlights

Highlights of GAO-05-855T, a testimony before the Committee on Finance, U.S. Senate

June 28, 2005

MEDICAID FRAUD AND ABUSE

CMS's Commitment to Helping States Safeguard Program Dollars Is Limited

Why GAO Did This Study

Today's hearing addresses fraud and abuse control in Medicaid, a program that provides health care coverage for eligible low-income individuals and is jointly financed by the federal government and the states. In fiscal year 2003, Medicaid covered nearly 54 million people and the program's benefit payments totaled roughly $261 billion, of which the federal share was about $153 billion.

States are primarily responsible for ensuring appropriate payments to Medicaid providers through provider enrollment screening, claims review, overpayment recoveries, and case referrals. At the federal level, the Centers for Medicare & Medicaid Services (CMS) is responsible for supporting and overseeing state fraud and abuse control activities. Last year, GAO reported that CMS had initiatives to assist states, but the dollar and staff resources allocated to oversight suggested that CMS's level of effort was disproportionately small relative to the risk of federal financial loss.

Concerned about the stewardship of federal Medicaid funds, this Committee has raised questions about CMS's commitment to Medicaid fraud and abuse control. This statement focuses on (1) the level of resources CMS currently applies to helping states prevent and detect fraud and abuse in the Medicaid program and (2) the implications of this level of support for CMS fraud and abuse control activities.

www.gao.gov/cgi-bin/getrpt?GAO-05-855T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz at (312) 220-7600.

What GAO Found

Since GAO reported last year, the resources CMS expends to support and oversee states' Medicaid fraud and abuse control activities remain out of balance with the amount of federal dollars spent annually to provide Medicaid benefits. In fiscal year 2005, CMS's total staff resources allocated to these activities was about 8.1 full-time equivalent (FTE) staffing units—approximately 3.6 FTEs at headquarters and 4.5 FTEs in the regional offices. Among CMS's 10 regional offices—each of which oversees states whose Medicaid outlays include billions of federal dollars—7 offices each have a fraction of an FTE and the rest each have less than 2 FTEs allocated to Medicaid fraud and abuse control efforts. Moreover, the placement of the Medicaid fraud and abuse control staff at headquarters—apart from the agency's office responsible for other antifraud and abuse activities—as well as a lack of specified goals for Medicaid fraud and abuse control raise questions about the agency's level of commitment to improve states' activities in this area.

CMS's support and oversight initiatives include a pilot project for states to enhance claims scrutiny activities by coordinating with the Medicare program. Despite the project's positive results in several states, less than one-fifth of the states currently participate in the project and resource constraints may require CMS to scale back these efforts instead of expanding them to additional states that are seeking to participate. Similarly, CMS's support activities—such as conducting national conferences, regional workshops, and training—have been terminated altogether. The frequency of CMS's on-site reviews of states' fraud and abuse control activities—about seven to eight visits a year—has not changed since GAO reported on this last year. This means that federal oversight of a state's Medicaid program safeguards will not occur, at best, more than once every 7 years.

Relatively few and questionably aligned resources and an absence of strategic planning underscore the limited commitment CMS has made to strengthening states' ability to curb fraud and abuse. Despite the millions of dollars CMS receives annually from a statutorily established fund for fraud and abuse control, the agency has not allocated these resources to sufficiently fund initiatives that can help states increase the effectiveness of their Medicaid fraud and abuse control efforts. Developing a strategic plan for Medicaid fraud and abuse control activities would give CMS a basis for providing resources that reflect the financial risk to the federal government.

In discussing the facts in this statement with a CMS Medicaid official, he stated that the agency does not view antifraud and abuse initiatives as separate from financial oversight, an area that has received substantial resources in recent years. While we agree that financial management is important to program integrity, we believe that an increased commitment to helping states fight fraud and abuse is warranted.

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss fraud and abuse control in Medicaid, a program that provides health care coverage for eligible low-income individuals and is jointly financed by the federal government and the states. In fiscal year 2003, Medicaid covered nearly 54 million people, and the program's benefit payments totaled $261 billion, of which the federal share was about $153 billion. Because fraud and abuse by their nature are unknown until detected, the amount of Medicaid funds lost through health care providers' inappropriate billings cannot be precisely quantified. Some states have made estimates of their respective programs' improper Medicaid payment rates that reflect not only fraudulent and abusive billings but also inadvertent billing errors, such as clerical mistakes. A nationwide improper payment rate for Medicaid has not been made, but even a rate as low as 3 percent would mean a loss of almost $4.6 billion in federal funds in fiscal year 2003. To put this hypothetical figure in perspective, it is roughly the amount that the federal government spent in fiscal year 2003 on the State Children's Health Insurance Program (SCHIP).[1]

Such a drain of vital program dollars is a detriment to both taxpayers and beneficiaries. For example, paying for services billed but not provided wastes funds that could have been used for health care. For example, in 2004, the owners of a Louisiana health care clinic were found guilty of billing the program more than $400,000 for health care screening services, nurse consultations, and nutrition consultations never provided. Alternatively, paying for unnecessary services can have a substantial, if not quantifiable, impact on health care quality. Consider the charge in 2004 against 20 dentists in California for conspiracy to defraud the state's Medicaid program of $4.5 million. As part of the conspiracy, the dentists billed Medicaid for unnecessary or inappropriate services that placed patients at risk by reusing dental instruments without sterilizing them, performing dental surgeries without adequate anesthesia, developing treatment plans that called for unneeded root canals and fillings, and forcibly restraining children during dental operations.

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[1] SCHIP is a jointly funded federal-state program that provides health insurance to children in low-income families who do not qualify for Medicaid and are not covered by other insurance.

States are primarily responsible for the fight against Medicaid fraud and abuse. Specifically, they are responsible for ensuring the legitimacy of providers billing the program, detecting improper payments, recovering overpayments, and referring suspected cases of fraud and abuse to law enforcement authorities. At the federal level, the Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services (HHS) is responsible for supporting and overseeing state fraud and abuse control activities. Last year, we reported that CMS had initiatives to assist states in combating fraud and abuse in their Medicaid programs, but its oversight of states' activities in this area was limited.[2] The dollar and staff resources allocated to compliance reviews suggested that CMS's level of effort was disproportionately small relative to the risk of serious financial loss.

Concerned about the stewardship of federal Medicaid funds, this Committee has raised questions about CMS's commitment to Medicaid fraud and abuse control. It is important to note that activities designed to prevent, detect, and recover improper payments made to providers resulting from fraud and abuse are a component of ensuring Medicaid program integrity. These activities are valuable not only from a financial standpoint but also have a sentinel effect on providers that may otherwise consider billing the program inappropriately. Another component is financial management activities, which involve the oversight of state claims for federal reimbursement, including the matching, administrative, and disproportionate share funds that CMS provides the states.[3] While these program integrity functions are related, they are not interchangeable. My remarks today will focus on (1) the level of resources CMS currently applies to helping states prevent and detect fraud and abuse in the Medicaid program and (2) the implications of this level of support for CMS fraud and abuse control activities.

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[2] GAO, *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments*, GAO-04-707 (Washington, D.C.: July 16, 2004).

[3] Since fiscal year 2004, CMS has nearly completed the hiring of new staff accounting for 100 full-time equivalent positions to support its financial management review activities. Located largely in CMS regional offices, these staff review state budget and expenditure reports for accuracy, identify unallowable program costs, and provide guidance to the states on Medicaid financial management matters. Although financial management reviews are not intended to identify inappropriate billings by providers, they can identify fraud and abuse leads on an incidental basis.

To do this work, we reviewed agency documents on Medicaid program safeguard support and oversight activities as well as our issued reports on this topic. We also interviewed officials at headquarters and CMS's 10 regional offices. We conducted our work in May and June 2005 in accordance with generally accepted government auditing standards.

In summary, since we reported last year, the resources CMS expends to support and oversee states' Medicaid fraud and abuse control activities remain out of balance with the amount of federal dollars spent annually to provide Medicaid benefits.[4] In fiscal year 2005, CMS's total staff resources allocated to these activities was about 8.1 full-time equivalent (FTE) staffing units—approximately 3.6 FTEs at headquarters and 4.5 FTEs in the regional offices. Among CMS's 10 regional offices—each of which oversees states whose Medicaid outlays include billions of federal dollars—7 offices each have less than 1 FTE and the rest each have less than 2 FTEs allocated to Medicaid fraud and abuse control efforts. Moreover, the placement of the Medicaid fraud and abuse control staff at headquarters—apart from the agency's office responsible for other antifraud and abuse activities—as well as a lack of specified goals for Medicaid fraud and abuse control raise questions about the agency's level of commitment to improving states' activities in this area.

CMS's support and oversight initiatives include a pilot project for states to enhance claims scrutiny activities by coordinating with the Medicare program. Despite the project's positive results in several states, less than one-fifth of the states currently participate in the project, and resource constraints may require CMS to scale back these efforts instead of expanding them to additional states that are seeking to participate. Similarly, some of CMS's other support activities—such as conducting national conferences, regional workshops, and training—have been terminated altogether. The frequency of CMS's on-site reviews of states' fraud and abuse control activities remains about seven to eight visits a year. This means that federal oversight of a state's Medicaid program safeguards will not occur, at best, more than once every 7 years.

In discussing the facts in this statement with a CMS Medicaid official, he stated that the agency does not view antifraud and abuse initiatives as separate from financial oversight, an area that has received substantial resources in recent years. While we agree that financial management is important to program integrity, we believe that an increased commitment to helping states fight fraud and abuse is warranted.

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[4] GAO-04-707.

Background

Although jointly financed by the states and the federal government, Medicaid is administered directly by the states and consists of 56 distinct state-level programs.[5] Within broad federal guidelines, each program establishes its own eligibility standards; determines the type, amount, duration, and scope of covered services; and sets payment rates. In general, the federal government matches state Medicaid spending for medical assistance according to a formula based on each state's per capita income. In fiscal year 2004, the federal contribution ranged from 50 to 77 cents of every state dollar spent on medical assistance. For most state Medicaid administrative costs, the federal match rate is 50 percent.[6]

As program administrators, states have primary responsibility for conducting program integrity activities that address provider enrollment, claims review, and case referrals. Specifically, federal statute or CMS regulations require states to

- collect and verify basic information on potential providers, including whether the providers meet state licensure requirements and are not prohibited from participating in federal health care programs;
- have an automated claims payment and information retrieval system—intended to verify the accuracy of claims, the correct use of payment codes, and patients' Medicaid eligibility—and a claims review system—intended to develop statistical profiles on services, providers, and beneficiaries to identify potential improper payments;[7] and
- refer suspected overpayments or overutilization cases to other units in the Medicaid agency for corrective action and potential fraud cases, generally,

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[5] The 56 Medicaid programs include one for each of the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories of American Samoa, Guam, Northern Mariana Islands, and Virgin Islands. Hereafter, all 56 entities are referred to as states.

[6] For skilled professional medical personnel engaged in program integrity activities, such as those who review medical records, 75 percent federal matching is available.

[7] CMS requires that states have certain information processing capabilities, including a Medicaid Management Information System and a Surveillance and Utilization Review Subsystem.

to the state's Medicaid Fraud Control Unit for investigation and prosecution.[8]

As noted in our 2004 report,[9] states use a variety of controls and safeguards to stem improper provider payments. For example, states target high-risk providers seeking to bill Medicaid with on-site facility inspections, criminal background checks, and probationary or time-limited enrollment. States also reported using information technology to integrate databases containing provider, beneficiary, and claims information and to increase the effectiveness of their utilization reviews. Various states individually attributed cost savings or recoupments to these efforts valued in the millions of dollars.

In contrast, CMS's role in curbing fraud and abuse in the Medicaid program is largely one of support to the states. As we reported last year,[10] CMS administers two pilot projects—one focused on measuring the accuracy of a state's Medicaid claims payments (Payment Accuracy Measurement (PAM)) and the other focused on improper billing detection and utilization patterns by linking Medicare and Medicaid claims information (Medi-Medi). CMS also sponsors general technical assistance and information-sharing through its Medicaid fraud and abuse technical assistance group (TAG). In addition, CMS performs oversight of states' Medicaid fraud and abuse control activities. (See table 1.)

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[8] Medicaid Fraud Control Units can, in turn, refer some cases to the HHS Office of Inspector General (OIG), the Federal Bureau of Investigation (FBI), and the Department of Justice (DOJ) for further investigation and prosecution.

[9] GAO-04-707.

[10] GAO-04-707.

Table 1: CMS Activities to Support and Oversee States' Fraud and Abuse Control Efforts, Fiscal Year 2004

CMS initiatives	Description
PAM/PERM	CMS conducted a 3-year pilot called PAM to develop estimates of the accuracy of Medicaid claims payments. In fiscal year 2006, PAM will become a permanent, mandatory program—to be known as the Payment Error Rate Measurement (PERM) initiative—as required by the Improper Payments Information Act of 2002.[a] Under PERM, states will be expected to ultimately reduce their payment error rates over time by better targeting program integrity activities in their Medicaid and SCHIP programs.
Medi-Medi	Under this program, CMS facilitates the sharing of information between the Medicaid and Medicare programs. Medi-Medi is a data match pilot designed to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information on providers and beneficiaries. Such matching is important, as fraudulent schemes can cross program boundaries.
TAG	Through telephone conferencing, CMS provides a forum for states to discuss issues, solutions, resources, and experiences on fraud and abuse issues. Any state may participate; roughly one-third do so regularly. States have also used the TAG to propose policy changes to CMS.
Compliance reviews	CMS conducts on-site reviews to assess whether state Medicaid fraud and abuse control efforts comply with federal requirements, such as those governing provider enrollment, claims review, utilization control, and coordination with each state's Medicaid Fraud Control Unit. If reviewers find states significantly out of compliance, they may revisit the states to verify that they have taken corrective action.

Source: GAO, *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments*, GAO-04-707 (Washington, D.C.: July 16, 2004).

[a] Pub. L. No. 107-300, 116 Stat. 2350.

CMS Expends Limited Resources and Lacks Coherent Plan to Improve States' Medicaid Fraud and Abuse Control Activities

A wide disparity exists between the level of resources CMS expends to support and oversee states' fraud and abuse control activities and the amount of federal dollars at stake in Medicaid benefit payments. In addition, CMS's organizational placement of staff and lack of strategic planning suggest a limited commitment to improving states' Medicaid fraud and abuse control efforts.

Disparity Exists between Level of Resources and Program's Financial Risk

The resources CMS devotes to working with states to fight Medicaid fraud and abuse do not appear to be commensurate with the size of the program's financial risk. In fiscal year 2005, CMS's Medicaid staff resources allocated to supporting or overseeing states' anti-fraud and abuse operations was an estimated 8.1 FTEs—3.6 FTEs at headquarters and 4.5 FTEs in the regional offices.[11] Staff at headquarters are engaged in arranging and conducting the on-site compliance reviews of states' fraud and abuse control efforts and in information-sharing activities. Staff at the regional offices also participate in the state compliance reviews and respond to state inquiries. Canvassing the 10 regional CMS offices, we found that 7 regions each have a fraction of an FTE and the rest each have less than 2 FTEs devoted to providing assistance on fraud and abuse issues. For example, Region IV—which covers eight states and accounted for $33 billion of federal funds for Medicaid benefits in fiscal year 2004—reported having 1 FTE devoted to Medicaid fraud and abuse control activities. (See table 2.)

Table 2: Federal Share of Medicaid Benefit Dollars and CMS Staff Devoted to States' Fraud and Abuse Control Efforts

CMS office	Office jurisdiction	Fiscal year 2004 federal share of Medicaid benefit outlays (dollars in billions)	Fiscal year 2005 CMS staff devoted to Medicaid fraud and abuse control (estimated FTEs)
Region I	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont	$9.2	Less than 1
Region II	New York, New Jersey, the U.S. Virgin Islands, and Puerto Rico	26.0	Less than 1
Region III	Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and the District of Columbia	15.2	Less than 1
Region IV	Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, and Tennessee	33.0	Less than 2

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[11] In addition, three to four Medicare FTEs located in both headquarters and regional offices support joint Medicaid and Medicare fraud and abuse projects.

CMS office	Office jurisdiction	Fiscal year 2004 federal share of Medicaid benefit outlays (dollars in billions)	Fiscal year 2005 CMS staff devoted to Medicaid fraud and abuse control (estimated FTEs)
Region V	Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin	25.9	Less than 2
Region VI	Arkansas, Louisiana, New Mexico, Oklahoma, and Texas	19.2	Less than 2
Region VII	Iowa, Kansas, Missouri, and Nebraska	7.4	Less than 1
Region VIII	Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming	3.8	Less than 1
Region IX	Arizona, California, Hawaii, Nevada, the territories of American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands	20.9	Less than 1
Region X	Alaska, Idaho, Oregon, and Washington	5.6	Less than 1
All regions			4.5
CMS headquarters			3.6
Total CMS		**$166.1**	**8.1**

Source: GAO compilation of CMS information.

Note: Federal outlays do not add up to the total due to rounding.

For fiscal year 2006, CMS's budget has no line item devoted to Medicaid fraud and abuse control activities. The project to estimate payment error rates known as PAM/PERM (required by statute) and the Medi-Medi pilot project (with benefits accruing to both programs) are financed through a statutorily established fund—the Health Care Fraud and Abuse Control (HCFAC) account.[12] (See table 3.) The HCFAC monies from which these two projects are financed are known as "wedge" funds. As CMS's distribution of these funds varies from year to year, the level of support for fraud and abuse control initiatives is uncertain and depends on the priorities set by the agency. For example, fiscal year 2005 funds allocated from the HCFAC account for PAM/PERM and Medi-Medi were less than half the funds allocated in fiscal year 2004. In contrast, Medicare fraud and abuse control activities at CMS are financed primarily through earmarked funds from another HCFAC component—the Medicare Integrity Program.

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[12] Since fiscal year 2003, this account dedicates $1.075 billion annually from the Medicare part A Trust Fund for combating health care fraud and abuse. The money is allocated in three major parts: (1) up to $720 million for the Medicare Integrity Program, (2) $114 million to the FBI, and (3) up to $240.6 million in "wedge" funds. In fiscal years 2004 and 2005, wedge funds were allocated as follows: $160.0 million to the HHS OIG, $49.4 million to DOJ, and $31.1 million to CMS and other HHS agencies.

Table 3: HCFAC Funds Allocated for CMS Activities That Address Medicaid Fraud and Abuse

Dollars in thousands

	Fiscal year 2004	Fiscal year 2005
PAM/PERM	$4,121	$1,200
Medi/Medi (Medicaid share)	3,691	2,439
Total	**$7,812**	**$3,639**

Source: CMS.

CMS's Medicaid compliance reviews are funded through a different source—HHS's budget appropriation. In fiscal year 2004, the budget for this activity was $26,000, down from $40,000 in fiscal year 2003 and $80,000 in fiscal year 2002.[13]

CMS Structure and Lack of Planning Suggest Weak Commitment to Supporting States' Medicaid Fraud and Abuse Control Efforts

The placement of Medicaid's antifraud and abuse function in CMS's organizational structure and a lack of stated goals and objectives suggests a limited institutional commitment to Medicaid fraud and abuse control activities. Currently, two different headquarters offices are charged with working with states on fraud and abuse issues. CMS's Office of Financial Management staffs the PAM/PERM and Medi-Medi initiatives, while the Center for Medicaid and State Operations (CMSO) staffs the state compliance reviews and TAG functions. Under this organizational structure, the Medicaid fraud and abuse staff in CMSO are not in an optimal position to leverage the resources allocated to the office with responsibility for developing tools and strategies for combating fraud and abuse.

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[13] Information on the amount of fiscal year 2005 funds for compliance reviews was not available at the time of our review.

As further evidence of the low priority assigned to Medicaid fraud and abuse control, the planning, outreach, and building of staff expertise lacks leadership continuity. From 1997 to 2003, the leadership and funding of CMS's support for states' antifraud and abuse efforts resided in a consortium of two regional offices. The consortium led a network of regional fraud and abuse coordinators and state Medicaid representatives, sponsoring telephone conferences and workshops, seminars, and training sessions aimed at sharing best practices for fighting fraud and abuse. Medicaid staff based at headquarters reported to a national network coordinator located at one of the consortium's regional offices. With the retirement of the national coordinator in 2003, the consortium relinquished its leadership and funding role and the Medicaid antifraud and abuse activities were reassigned to CMSO without additional resources. Since then, no nationwide meetings with state program integrity officials have been held.

At the same time, CMS lacks a strategic plan to drive its Medicaid antifraud and abuse operations. Goals for the long term, as well as plans on how to achieve them, have not been specified in any public department or agency planning documents. For example, HHS's fiscal year 2004 performance and accountability report cited Medicaid's high risk of payment errors as the department's management challenge for fighting Medicaid fraud and abuse.[14] To address this challenge, the report cited the PAM/PERM initiative for estimating payment error rates, as this activity is required in federal statute. But there was no mention of any other fraud and abuse support or oversight activities or goals. Similarly, the discussion of Medicaid program integrity in the Administration's *Budget for Fiscal Year 2006* covers activities to curb states' inappropriate financing mechanisms but makes no mention of federal support or oversight of states' fraud and abuse efforts. At the agency level, CMS officials were unable to provide any publicly available planning documents specifying short- or long-term Medicaid program goals that target fraud and abuse.

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[14] HHS, *Performance and Accountability Report, Fiscal Year 2004* (Washington, D.C.: Dec. 13, 2004).

Lack of Priority Threatens CMS's Medicaid Fraud and Abuse Control Activities, While Potential to Do More Goes Untapped

The low priority given to CMS activities in support of states' fraud and abuse control efforts is having serious consequences for current projects. CMS's distribution of resources may require some activities to be scaled back and others to be eliminated.

Specifically, the expansion of the Medi-Medi data match project has been slow, leaving potentially millions of dollars in cost avoidance and cost savings unrealized. This project enables claims data analysts to detect patterns that may not be evident when providers' billings for either Medicare or Medicaid are viewed in isolation. For example, by combining data from each program, analysts can identify "time bandits," or providers who bill for more than 24 hours in a single day. As of March 31, 2005, seven states with fully operational projects reported returns to the Medicaid and Medicare programs of $133.1 million in provider payments under investigation, $59.7 million in program vulnerabilities identified, and $2.0 million in overpayments to be recovered. In addition, 240 investigations had been initiated and 28 cases referred to law enforcement agencies. Two additional states, Ohio and Washington, have begun Medi-Medi projects that are expected to be operational later this year.

Because of anticipated unmet funding needs, existing Medi-Medi data match activities are in jeopardy of being scaled back considerably. As CMS stated in its fiscal year 2005 second quarter report on Medi-Medi projects, "Eliminating certain Medi-Medi projects in their entirety and/or dramatically reducing the level of effort across all of the projects are among the approaches under consideration. Beyond FY 2006, the entire project will terminate if additional funding is not identified." Agency officials noted that several additional states have expressed interest in participating but expanding the program to more states will not occur without a new allocation or realignment of resources. Plans for additional activities that involve coordination with Medicare have been put on hold, pending budget decisions. These include enhanced oversight of prescription drug fraud when Medicare begins covering Medicaid beneficiaries' drug benefits in 2006 and the use of a unified provider enrollment form instead of separate forms for Medicare and Medicaid.

Similarly, CMS's role as provider of technical assistance and disseminator of states' best practices has been severely limited because of competing priorities. At a health care fraud and abuse conference sponsored by HHS and the Department of Justice in 2000, participants from states and CMS regional offices articulated their common unmet needs with regard to fraud and abuse technology. The top three areas cited were information-sharing and access to data; training in data analysis and use of technology;

and staffing, hardware, and software resources. CMS has not sponsored a national conference with state program integrity officials since 2003 and has not sponsored any fraud and abuse workshops or training since 2000. According to a CMS official, such information-sharing and technical assistance activities would not be expensive to support—less than $100,000 annually—and could result in returns that would exceed this relatively low amount.

Resource shortages also account for CMS's limited oversight of states' Medicaid prevention, detection, and referral activities for improper payments. Since January 2000, CMS's Medicaid staff from headquarters and regional offices have been conducting compliance reviews of about seven to eight states a year. The reviews are aimed at ensuring that states have processes and procedures in place, in compliance with federal requirements for enrolling providers, reviewing claims, and referring cases. These compliance reviews have been effective at identifying weaknesses in states' efforts to combat fraud and abuse. For example, in the course of these reviews, CMS has found instances in which

- a state had no process in place to prevent payments to excluded providers,
- states did not use their authority to evaluate providers' professional or criminal histories as part of the provider enrollment process, and
- a state did not follow appropriate procedures for referring a case to state law enforcement authorities.

States have reported making positive modifications in their programs as a result of the CMS compliance reviews. Nevertheless, at the currently scheduled pace, states' programs will be reviewed once in 7 years at the earliest. Because the compliance reviews are infrequent, CMS's knowledge of states' fraud and abuse activities is, for many states, substantially out-of-date at any given time.

Concluding Observations

Relatively few and questionably aligned resources and an absence of strategic planning underscore the limited commitment CMS has made to strengthening states' ability to curb fraud and abuse. Despite the millions of dollars CMS receives annually from a statutorily established fund for fraud and abuse control, the agency has not allocated these resources to sufficiently fund initiatives that can help states increase the effectiveness of their Medicaid fraud and abuse control efforts. Developing a strategic plan for Medicaid fraud and abuse control activities would give CMS a basis for providing resources that reflect the financial risk to the federal government.

We discussed facts in this statement with a relevant CMS official. He noted that CMS does not view fraud and abuse control activities as separate from its financial management responsibilities. He indicated that CMS has invested substantial resources in program integrity activities that focus on the financial oversight of the Medicaid program. While we agree that financial oversight of Medicaid is a key component of program integrity, we maintain that the other component—fraud and abuse control activities—warrants a greater commitment than it currently receives.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions that you or other Members of the Committee may have.

Contact and Acknowledgments

For further information regarding this testimony, please contact Leslie G. Aronovitz at (312) 220-7600. Hannah Fein, Sandra Gove, and Janet Rosenblad contributed to this statement under the direction of Rosamond Katz.

GAO
Accountability • Integrity • Reliability

United States Government Accountability Office
Washington, DC 20548

August 4, 2005

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate

Dear Mr. Chairman:

On July 18, 2005, you forwarded questions from members of the Committee following the June 28, 2005, hearing, entitled "Medicaid Waste, Fraud, and Abuse: Threatening the Health Care Safety Net." Below are my responses.

Question from Senator Grassley

Your testimony discussed a pilot program at the Centers for Medicare & Medicaid Services (CMS) called Medi-Medi. The program is a data matching program that compares reimbursement records for both Medicare and Medicaid to see if any significant outliers exist that tend to be fraudulent expenditures. You discussed significant savings that this pilot program was generating; however you also stated that even with the savings that have been generated, the program is effectively being "zeroed out" in the FY 2006 budget for CMS. To the best of your ability, could you please discuss the potential savings that a program such as Medi-Medi could provide if it were pursued more aggressively by CMS?

GAO Response

Because the benefits of the Medicare-Medicaid (Medi-Medi) data match projects are multidimensional and difficult to quantify, they do not lend themselves to a single "savings" estimate. Indicators of success and effectiveness compiled quarterly by CMS include potential dollars at risk (estimated amounts paid to providers that relate to the allegations under investigation) and estimated impact of vulnerabilities (potential amounts at risk resulting from program vulnerabilities that have been identified).

According to CMS, from February 2002 through March 2005, the Medi-Medi project in California has resulted in an estimated $76 million in potential dollars at risk and about $23 million in program vulnerabilities identified. Given the overall success of the project in California, CMS expanded Medi-Medi to six other states: Texas, Illinois, North Carolina, Florida, New Jersey, and Pennsylvania. From May 2004, when programs in these states became been fully operational, through March 2005, these six states estimated

$57 million for potential Medicare and Medicaid dollars at risk and about $37 million attributable to program vulnerabilities. Two other expansion states, Ohio and Washington, are working with CMS to reach full operational status later this year, and other states have expressed interest in having Medi-Medi in their programs.

CMS officials we spoke with believe that these data demonstrate the value of blending both programs' claims for data matching and data mining. The Director, Center for Medicaid and State Operations, reported that he has spoken directly with CMS's Administrator, Mark McClellan, about continued financial support for Medi-Medi and his desire to expand it to other states.

Question from Senator Baucus

Ms. Aronovitz, I am concerned about CMS's enforcement of its new policy on intergovernmental transfers (IGT), which appears to be inconsistent and confusing to states. Do you think states are being given adequate notices of the requirements? Is CMS consistently applying these requirements?

GAO Response

In our June 2005 report conducted under the direction of my colleague, Kathryn Allen,[1] we concluded that CMS policies related to supplemental payment arrangements (some of which use IGTs as a mechanism for creating illusory payments to benefit the state) should be clarified and consistently applied to states. We reported that problematic contingency-fee projects involved categories of Medicaid claims where federal policy were inconsistently applied, evolving, or not specific. We recommended that CMS establish or clarify its policies on supplemental payment arrangements and several other payment areas. Specifically, we recommended that CMS establish or clarify and then communicate its policies on allowable claims for targeted case management services, supplemental payment arrangements, rehabilitation services, and Medicaid administrative costs, and ensure that the policies are applied consistently across all states.

We have work ongoing for the Committee on Finance, U.S. Senate, which will more completely address the issue of state notification and consistent application of requirements. We are reviewing CMS's current enforcement process including the extent to which CMS's actions reflect a change in policy and practice regarding its oversight of state financing methods.

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[1] See GAO, *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight,* GAO-05-748 (Washington, D.C.: June 28, 2005).

Questions from Senator Hatch

(1) While you were conducting your study, were you able to find out about collaborative partnerships between states and the federal government for combating fraud and abuse in Medicaid?

GAO Response

The most outstanding example of state-federal partnerships in addressing fraud and abuse problems is the Medi-Medi projects operating in several states. The data matching pilot was developed to examine federal Medicare claims and state Medicaid claims data for common beneficiaries and providers. Analysts can then identify aberrancies indicative of potential fraud or abuse that may not be evident when provider billings for either program are viewed in isolation. In this way, the project helps eliminate program vulnerabilities and reduce payment errors.

(2) I read Table 2 of your testimony with much interest. This table shows how the federal share of Medicaid benefit dollars and CMS staff devoted to states' fraud and abuse control efforts. How did GAO determine how many FTEs CMS devoted to fraud and abuse efforts in each region? What was CMS's reaction to your analysis?

GAO response

The information we reported in table 2 of our testimony was obtained by canvassing each of the 10 CMS regional offices. In most instances we spoke with the associate regional administrator for Medicaid. Each was asked to estimate the number of full-time equivalent (FTE) staff devoted to working with states on Medicaid fraud and abuse issues. As shown in the table, the officials in 7 regions each estimated less than one FTE and officials in the rest of the regions each estimated less than two FTEs.

We discussed this finding with the Director, Center for Medicaid and State Operations. While he was unable to verify whether our staff estimate for CMS's Medicaid fraud and abuse activities was accurate, he noted that these staff are part of the broader program integrity effort. He does not view fraud and abuse control activities as separate from CMS's financial management responsibilities. He stressed the need to acknowledge the "bigger picture" when considering resources devoted to this area.

(3) You say that in FY2006, CMS's budget has no line item devoted to fraud and abuse control. While I understand the point you are making, does that necessarily mean that CMS is not going to devote resources to fraud and abuse control? What did CMS officials tell you when you raised this specific point with them? I am troubled by your statement that the placement of Medicaid's antifraud and abuse function in CMS's organizational structure and a lack of state goals and objectives suggests a limited institutional commitment to Medicaid fraud and abuse control activities. I

respectfully disagree with your assessment of CMS and believe that Dr. Mark McClellan and his staff have done a good job overall in running the agency.

GAO Response

In fiscal year 2003, Medicaid benefit payments totaled roughly $261 billion, of which the federal share was about $153 billion. Given the large amount of federal dollars at risk, we sought to determine CMS's institutional commitment—in terms of staffing, funding, and planning—to helping states fight fraud and abuse in their Medicaid programs. We found the following:

(1) CMS devotes 3.6 FTEs in the central office and 4.5 FTEs across all of the regional offices to working with states to curb waste, fraud, and abuse in the Medicaid program. Because the headquarters staff are situated in a component apart from Medicare staff who deal with fraud and abuse control issues, they cannot easily leverage that expertise. In general, CMS regional office representatives told us that their staff typically are available to respond to questions that may come in from state program integrity officials.

(2) Because of limited staff resources, CMS can only conduct seven to eight state Medicaid compliance reviews each year. This means that oversight of each state's antifraud and abuse efforts will occur about once every seven years.

(3) CMS has been slow to expand the number of states participating in the Medi-Medi pilot project, and agency officials are now considering a reduction in funds available to continue operating the program.

(4) Information sharing through conferences and training has been virtually eliminated.

(5) There is no documented plan that addressed CMS goals and strategies for working with states to improve Medicaid fraud and abuse control activities.

In discussing these findings, the Director, Center for Medicaid and State Operations pointed out that he does not view fraud and abuse control activities separately from financial management activities but rather he sees them as a set of program integrity responsibilities that CMS must fulfill. He noted that while there might not be any public strategy or planning documents that pertain specifically to fraud and abuse control efforts, the agency has made Medicaid program integrity a high priority through its financial management activities. To this end, the agency has invested substantial resources—hiring 100 new analysts—to conduct financial oversight of state Medicaid programs.

The key difference between our perspective and that of CMS is that we understand fraud and abuse control efforts to be distinct from financial management. The former category, the focus of our testimony, aims to prevent, detect, and recover improper payments to Medicaid providers. The latter is designed to prevent, detect, and recover improper reimbursement to states. In blurring this distinction, CMS cannot effectively allocate resources between these two important responsibilities. What we observed is that support for state fraud and abuse control efforts is declining as financial management activities become more prominent. We think it is important to maintain both components to properly ensure Medicaid program integrity.

If you or your staff have further questions, please contact me at (312) 220-7767 or aronovitzl@gao.gov.

Sincerely yours,

Leslie G Aronovitz

Leslie Aronovitz
Director, Health Care

Department of Justice

STATEMENT

OF

TIMOTHY J. COLEMAN
SENIOR COUNSEL TO THE DEPUTY ATTORNEY GENERAL
DEPARTMENT OF JUSTICE

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

CONCERNING

MEDICAID FRAUD AND ABUSE BY PHARMACEUTICAL COMPANIES

PRESENTED ON

JUNE 29, 2005

Mr. Chairman, I appreciate the opportunity to appear before you to discuss some of the issues that are the focus of today's hearing. We are grateful for the Committee's leadership on this important topic and to you, Mr. Chairman, for allowing us this opportunity to discuss our enforcement efforts and to work with your staff to fashion solutions to some of the systemic problems we will discuss here today.

We work with the Medicaid programs across the country to identify Medicaid losses in the broad range of health care fraud cases we bring against health care providers. Successful cases brought by the Department include issues implicating illegal kickbacks, false claims, illegal diversion of prescription drugs, and failure of care. Today, I am focusing my remarks on pharmaceutical pricing schemes perpetrated against state Medicaid programs because that area, in pure dollar terms, has been the most significant seen by the Department. If the Chairman would find it useful, I will be glad to fully brief Committee staff on the efforts of the Department in these and other areas of Medicaid fraud. The Department of Justice remains committed to rooting out and punishing corporate wrongdoers and that commitment takes on even added urgency in the context of health care fraud, where the public dollars are so large and where fraud often has a direct impact on public health. And that is why the Department of Justice, through the Civil and Criminal Divisions and through the U.S. Attorney's Offices, continues to fairly and vigorously enforce the various laws at our disposal to deal with those companies and individuals that steal from the taxpayers.

By no means, however, is the Department of Justice, and its investigative component, the FBI, alone in the fight to combat fraud and preserve the integrity of the country's health care system. We work closely with our colleagues at the Centers for Medicare and Medicaid Services, at the Department of Health and Human Services and its Inspector General, and with our State law enforcement partners in their Offices of Attorneys General and Medicaid Fraud Control Units. Working with our colleagues, in the past six years the Department has obtained recoveries exceeding $2 billion in pharmaceutical fraud matters involving losses to federal and state programs.

This Committee now is considering ways to protect state Medicaid programs from schemes involving pharmaceuticals. It is clear from our experience that government healthcare programs continue to pay too much for prescription drugs. This is due to several factors, including, unfortunately, the illegal behavior of those who seek to manipulate the system. It is equally clear that the Medicaid program is facing abuses of its prescription drug program, compounded by the fact that it pays significantly more for prescription drugs than the Medicare program currently does. This fact is borne out by the successful investigations we have brought, many of which are initiated by *qui tam* relators possessing "inside" knowledge. The lessons learned from these cases may prove useful to you as you consider possible reforms.

Let me discuss a few of these cases:

Bayer Corporation entered into two settlements with the Department to resolve allegations arising from its sale of pharmaceuticals and biological products to government health care programs.

In a case settled in 2001, the initial allegations against Bayer came to the Department from a relator under the False Claims Act who alleged that Bayer improperly inflated its drug prices, causing government programs, including Medicaid, to pay inflated reimbursement. Infusable and injectable drugs that cannot be purchased over the counter by the public at a retail pharmacy were at issue, including biologics used to treat life-threatening illnesses, such as hemophilia and immune deficiency diseases.

As you may know, state Medicaid programs reimburse providers for the purchase of these drugs for covered beneficiaries and use either the Average Wholesale Price (AWP) or Wholesale Acquisition Cost (WAC). The Government alleged that Bayer artificially inflated its AWPs and WACs above the actual prices paid by the vast majority of its customers when purchasing directly from Bayer or through a wholesaler. We alleged that Bayer, in turn, reported those inflated prices to the national drug pricing reporting services used by the States to calculate Medicaid reimbursement. By setting and reporting these prices, and subsequently selling the product to doctors at a dramatic discount, Bayer induced physicians to purchase its products rather than its competitors' because of the profit they would realize from government reimbursement for Bayer purchases, a corrupt practice known as "marketing the spread." The Government also alleged that Bayer falsely reported that certain products were not sold to wholesalers to avoid reporting accurate wholesale or distributor price information, and that it misled Medicaid officials about the prices it charged to wholesale purchasers. Bayer agreed to pay a total of $14 million to settle these allegations, as well as claims that Bayer underpaid Medicaid rebates owed to the states by not factoring in certain price concessions.

In a second case settled with Bayer two years later, the Medicaid rebate statute was again at issue. Bayer paid $257.2 million to settle allegations of fraudulent "private labeling" of certain drugs for some of its HMO customers to evade Medicaid rebate liability, and derivative Public Health Service liability. As part of the Medicaid rebate program, as you may know, manufacturers such as Bayer enter into a rebate agreement with the Centers for Medicare and Medicaid Services (CMS). Under the rebate program, manufacturers such as Bayer agree to report their best price to CMS on a quarterly basis. This best price is defined as the lowest price available from the manufacturer to any “wholesaler, retailer, provider, health maintenance organization, nonprofit entity or governmental entity within the United States” with certain specified exclusions. This law requires that manufacturers determine best price “without regard to special packaging, labeling, or identifiers on the dosage form or product or package.” 42 U.S.C. § 1396r-8(c)(1)(C)(ii)(II). It also requires that manufacturers pay rebates to each State Medicaid program each quarter, calculated as the product of (i) the total number of units of each dosage form and strength paid for under the State plan in the rebate period, and (ii) the greater of either the difference between average manufacturer price and best price, or a minimum rebate percentage of the average manufacturer. §§ 42 U.S.C. 1396r-8(c)(1)(A) and (B). The purpose of the rebate program is to ensure that the nation’s insurance program for the poor receives the best price for drugs available in the marketplace.

We have determined through our investigations that such "private labeling" has been used by some manufacturers to affix the customer's label and, more importantly, the customer's National Drug Code (NDC) to the drug, in a fraudulent scheme to avoid the manufacturer's statutory reporting or payment obligations with respect to that drug. Although private labeling has legitimate uses in the industry, for example, where a chain pharmacy wants to offer a store brand in addition to a brand name product, the practice may run afoul of the Medicaid Rebate program, 42 U.S.C. §§1396r-8, where it is done to avoid the manufacturer's best price reporting or rebate obligations.

In the Bayer investigation, the United States Attorney's Office in Boston alleged that Bayer private labeled two of its most popular drugs, Cipro and Adalat CC. We alleged that Bayer's private label arrangements were intended to provide deeply discounted prices on these drugs to the HMOs while evading its statutory and contractual obligations to provide the same favorable prices to the Medicaid program. In addition, Bayer submitted false statements to the Office of Audit of the Inspector General for the Department of Health and Human Services (HHS-OIG) and to the Food and Drug Administration (FDA) to further conceal its obligation to pay additional Medicaid rebates in connection with private labeling.

The Government's investigation concluded that Bayer failed to pay rebates owed to the Medicaid program and overcharged certain Public Health Service entities at least $9.4 million. Bayer pled guilty in the District of Massachusetts to a one count criminal Information charging violation of the Federal Food, Drug and Cosmetic Act for failing to list the private label product with the FDA, in violation of 21 U.S.C. §§ 331(p), 333(a)(2), and 360(j), and it paid a criminal fine of nearly $5.6 million. Together with the agreed upon civil settlement amount of $251.6 million, the total resolution in this second Bayer matter was $257.2 million

In a related investigation, **GlaxoSmithKline (Glaxo)** paid $87.6 million to settle similar allegations based on its relationship with the HMO, Kaiser Permanente Medical Care Program (Kaiser). As I indicated earlier, federal law requires drug manufacturers participating in the Medicaid program to report their "best prices" to the Federal government, and to pay rebates to Medicaid to ensure that the nation's insurance program for the poor receives the same favorable drug prices offered to other large purchasers of drugs.

We learned that at the time of our investigation, Kaiser provided care and treatment to more than 6 million persons and often purchased drugs directly from drug manufacturers to save on costs for its members. That is perfectly legal. However, we learned also that Glaxo – much like Bayer had done – provided discounted prices to Kaiser for its drugs and engaged in "private labeling" for Kaiser, affixing different labels to its drug products to avoid reporting the low prices to CMS. Glaxo also repackaged and privately labeled Paxil, an anti-depressant, and Flonase, a nasal spray, at discounted prices for Kaiser and then failed to report these lower prices as part of its mandated "best price" calculation submitted to the government.

This settlement with Glaxo involved not only the federal government but also 49 States, the District of Columbia, and Public Health Service entities to address losses suffered by the Medicaid programs and the Public Health Service entities. When added to the previous Bayer settlement, Bayer and GSK paid over $344 million to resolve these related allegations.

Like Bayer, GSK also executed a corporate integrity agreement with HHS-OIG, designed to ensure that GSK (like Bayer) will accurately report its "best price" information to the Government.

In the largest settlement of its kind, **TAP Pharmaceutical Products Inc. (TAP),** a joint venture between Abbott Laboratories and Takeda Chemical Industries, paid $875 million to resolve criminal charges and civil liabilities in connection with its fraudulent pricing and marketing of the cancer drug Lupron. Under an agreement with the Department in 2001, TAP pled guilty in the District of Massachusetts to a conspiracy to violate the Prescription Drug Marketing Act and paid a $290 million criminal fine. To resolve its civil liability under the False Claims Act, TAP agreed to pay the United States $559.4 million for filing fraudulent claims with Medicare and Medicaid, and to pay $25.5 million for filing fraudulent claims with the States.

During the period at issue, many state Medicaid programs, and the Medicare program, reimbursed covered drugs at the lower of 95% of the AWP or the physicians' actual charge. The Government alleged that TAP set and controlled the price at which the government programs reimbursed physicians for the prescription of Lupron by misreporting its AWP as significantly higher than the average sales price TAP offered physicians and other customers for the drug. TAP allegedly "marketed the spread" between its discounted prices paid by physicians and the significantly higher Medicare and Medicaid reimbursement based on AWP as an inducement to physicians to obtain their Lupron business. The Government further alleged that TAP concealed from Medicare and Medicaid the true discounted prices paid by physicians, and falsely advised physicians to report the higher AWP rather than the real discounted price for the drug. The "marketing the spread" practice was recently addressed in the HHS-OIG's Compliance Guidance for Pharmaceutical Manufacturers. The government further alleged that TAP knowingly offered and paid illegal remuneration in various forms, including free drug samples, to physicians and other entities to induce them to purchase the drug.

Another component of this case concerned TAP's failure to include the costs of the free goods it offered to physicians in its "patient start program"(under which urologists received free goods for every patient they switched to Lupron) in the Best Price calculations it reported to CMS. Our investigation determined that TAP knew that free goods contingent on future purchases must be included in Best Price calculations, but undertook no effort to include those discounts. As a result, TAP falsely reported its Best Price to CMS and underpaid its rebates to the states for several quarters.

In a related matter, **AstraZeneca Pharmaceuticals LP (AstraZeneca)** pled guilty in the District of Delaware to violating the Prescription Drug Marketing Act and paid $355 million to resolve criminal charges and civil liabilities in connection with its drug pricing and marketing practices arising from its sales of Zoladex, a drug used primarily for the treatment of prostate cancer and the main competitor product to TAP's Lupron.

AstraZeneca admitted it caused claims to be submitted for payment for the prescription of Zoladex which had been provided as free samples to urologists. As part of the plea agreement, AstraZeneca paid a $63.9 million criminal fine, paid $266.1 million to resolve allegations that the company caused false and fraudulent claims to be filed with the Medicare, TriCare and the Railroad Retirement Board Medicare programs, and paid $24.9 million to resolve allegations that its drug pricing and marketing misconduct resulted in false state Medicaid claims.

Our investigation revealed that AstraZeneca marketed Zoladex primarily for the treatment of prostate cancer, much like the drug Lupron produced by TAP. The United States alleged that from January 1991 through December 31, 2002, employees of AstraZeneca provided thousands of free samples of Zoladex to physicians, knowing and expecting that certain of those physicians would prescribe and administer the free drug samples to their patients and thereafter bill those free samples to the patients and to Medicare, Medicaid, and other federally funded insurance programs. In order to induce certain physicians, physicians' practices, and others to purchase Zoladex, AstraZeneca offered and paid illegal remuneration in various forms that included free Zoladex, unrestricted educational grants, business assistance grants and services, travel and entertainment, consulting services, and honoraria.

Also, to induce physicians to purchase Zoladex, the United States alleged that AstraZeneca marketed a "Return-to-Practice" program to physicians. In a scheme similar to that engaged in by TAP, AstraZeneca inflated the Average Wholesale Price used by Medicare and Medicaid for drug reimbursement, deeply discounted the price charged to physicians for the drug ("the discounted price"), and then marketed the spread between the AWP and the discounted price to entice physicians with the additional profit they stood to gain from Medicare and Medicaid. AstraZeneca set the AWP for Zoladex at levels far higher than what the majority of its physician customers actually paid. As a result, AstraZeneca's customers received reimbursement from Medicare and state Medicaid programs at levels significantly higher than the physicians' actual costs or the wholesalers' average price.

Much like in the TAP case, AstraZeneca also had an extensive free goods discounting program for urologists, including a program under which urologists received free goods for every patient switched to Zoladex, purportedly designed to familiarize office staff and patients with the delivery method of the drug. Many physicians reported in interviews with federal authorities that they understood these free samples and goods were an alternative way of giving additional pricing discounts for the drug. As I mentioned, free goods contingent on future purchases must be included in the calculation of the Medicaid Best Price reported to CMS, but AstraZeneca undertook no effort to include those discounts. Because it did not include free goods in its calculations of Best Price for Zoladex, AstraZeneca falsely reported its Best Price to CMS in each of the 24 quarters we examined and consequently underpaid its rebates to the states.

In 2004, Warrick, a division of **Schering Plough Corporation** (Schering) agreed to pay the United States and Texas $27 million to settle allegations that it had defrauded the Medicaid program by inflating its reported wholesale acquisition costs (WACs) to national reporting services, which are used to set Medicaid reimbursement. The government alleged that Warrick then marketed the spread between the Medicaid reimbursement and the actual lower purchase prices of the drugs in order to induce the purchasers to buy Warrick's products. In 2003, the state of Texas and the Department settled similar allegations with **Dey, Inc.** for $18.5 million.

In a significant matter resolved in 2004, Schering also paid $292.9 million to resolve allegations arising from its contracts with two managed care customers. The government alleged that contracts were entered into by Schering to ensure that Schering's drug, Claritin, stayed on the customers' formularies while evading its Medicaid rebate obligations and derivative Public Health Service liability. The government alleged that from 1998 through 2000, Schering provided additional "value" to PacifiCare to ensure that Claritin stayed on PacifiCare's formulary. Our investigation revealed that, with one exception, the value of these additional price concessions was not credited in Schering's calculation of the Medicaid "best price" reported to CMS and not used by the manufacturer in determining rebate obligations.

The investigation, conducted in the Eastern District of Pennsylvania, also determined that from 1999 through 2002, Schering provided additional "value" to Cigna to ensure that Claritin stayed on Cigna's formulary. Once again we concluded that none of the value of these additional price concessions was credited in Schering's calculation of its Medicaid best price reported to CMS and not used in determining rebate obligations. Schering paid more than $282.3 million to settle its Medicaid liability, and more than $10.6 million to resolve its liability to Public Health Service authorities.

A parallel criminal investigation was conducted against Schering and, as a result, Schering Sales Corporation, a Schering subsidiary, pled guilty to one count of offering and paying a kickback in violation of 42 U.S.C. §1320a-7b. The plea arose from Schering Sales Corporation's payment of a "data fee" for data already obtained in connection with Schering's efforts to maintain formulary status for Claritin at Cigna. Schering Sales Corporation paid a criminal fine in the amount of $52.5 million pursuant to the plea, over and above the $292.9 million paid to resolve its civil liability to date.

We commenced our investigation of **Parke-Davis**, a subsidiary of **Pfizer**, following the filing of a *qui tam* complaint by a relator who was a former executive for Parke-Davis and who worked on the account for the cholesterol-lowering drug, Lipitor. The relator alleged that Parke-Davis provided discounts to a large managed care account in Louisiana without properly reporting those discounts to CMS under the obligations created by the Medicaid Rebate program. Our investigation revealed that Parke-Davis provided discounts to the Louisiana managed care account in exchange for an agreement that the managed care account would extend unrestricted drug formulary status to Lipitor and sign a contract to buy Lipitor. The government alleged that these discounts were not reported to the CMS as part of the best price calculations, nor to the states. The matter settled when Pfizer paid $49 million to settle state and federal Medicaid claims.

In another matter resolved last year, the government alleged that **Warner-Lambert**, which was acquired by Pfizer in 2000, acting through its wholly-owned pharmaceutical division, **Parke-Davis**, engaged in the illegal marketing and promotion of the prescription drug Neurontin for uses that were not approved by the Food and Drug Administration. This was another matter initiated by the filing of a *qui tam* that alleged that the drug Neurontin, which had been approved by the FDA as an adjunct therapy for epilepsy, had been marketed by Pfizer for numerous other "off-label" and unapproved uses, such as for the treatment of pain and psychiatric conditions.

As a general proposition, the federal law and regulations governing Medicaid reimbursement do not provide for reimbursement for off-label prescriptions where the use is not medically accepted. The government alleged that Parke-Davis' marketing scheme induced physicians to prescribe Neurontin for off-label uses through a variety of means, including the fraudulent practices of the payment of kickbacks to doctors and distribution of false statements to doctors about the safety, efficacy and approval status of Neurontin. Neurontin was launched into the marketplace in February of 1994; from mid-1995 to at least 2001, the growth of off-label sales was tremendous. While not all of these sales were the consequence of Warner-Lambert's illegal marketing, the marketing scheme was very successful in increasing Neurontin prescriptions for unapproved uses.

Under the terms of the settlement, Warner-Lambert pled guilty in the District of Massachusetts to a criminal information charging it with violations of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. § 333(a)(2). Because Warner-Lambert was previously convicted of criminal violations under the Federal Food, Drug and Cosmetic Act in 1996, these misdemeanor offenses became felonies under 21 U.S.C. §333(a)(2). As part of the $430 million settlement amount, Warner-Lambert paid a criminal fine of $240 million and paid $190 million to resolve federal and state Medicaid claims, and to resolve state consumer protection claims.

Pfizer Inc., Warner-Lambert's parent company, has agreed to comply with the terms of a corporate compliance program, which will ensure that the changes Pfizer Inc. made after acquiring Warner-Lambert in June 2000, are effective in training and supervising its marketing and sales staff, and that any future off-label marketing conduct is detected and corrected on a timely basis.

In a recent matter handled by the United States Attorney's Office in Massachusetts and the Civil Division's Office of Consumer Litigation, on April 19, 2005, a Michigan medical device manufacturer and its president pled guilty to conspiring with others to disseminate adulterated computer software devices used to promote the diagnosis of AIDS wasting and to increase sales of an AIDS wasting drug. The drug, paid for by state Medicaid programs, cost more than $21,000 per twelve-week course of treatment, and thus more than $40,000 per patient per year for multiple courses of treatment.

The conspiracy involved **RJL Sciences**, its president, and others disseminating adulterated computer software devices for use in interpreting bioelectrical impedance analysis (BIA) for use in diagnosing AIDS wasting, without getting the necessary approvals from FDA. When required FDA approvals are not obtained for medical devices, the system for ensuring the safety and efficacy of devices is undermined, and the public is exposed to the risk that medical diagnoses and treatment decisions are based on diagnostic tools whose effectiveness have not been established. By circumventing the FDA approval process, the defendants and their co-conspirators put their desire to sell more drugs and devices over the interests of the public.

Demand for the AIDS wasting drug began to drop significantly immediately after it was launched as a result of a decline in the incidence and prevalence of AIDS wasting. AIDS wasting, the condition for which the drug was tested and approved by FDA, involves profound involuntary weight loss and loss of lean body mass in AIDS patients, and does not include loss of body cell mass. Use of computer software that purported to measure loss of body cell mass enabled RJL, and others, to expand the market for the drug beyond the disease state for which the drug was tested and approved. According to the Criminal Information, RJL and others engaged in various overt acts in furtherance of the conspiracy, including providing training and assistance to others in performing and interpreting BIA test results and obtaining reimbursement for the drug.

On April 14, 2005, in another investigation, four former top executives of the manufacturer of an AIDS wasting drug were indicted by a federal grand jury in the District of Massachusetts for conspiring to offer and pay kickbacks to doctors in the form of an all expense-paid trip for the doctors and their guests to attend a medical conference in Cannes, France in return for writing prescriptions for an AIDS wasting drug covered by Medicaid. The executives were also charged with offering to pay illegal remunerations.

The purpose of this conspiracy was also to increase the sale of an AIDS wasting drug by, among other things, achieving a sales goal of $6 million in six days, by inducing the writing of up to thirty prescriptions by each of the high prescribing doctors. Because the cost of each prescription of the AIDS wasting drug induced by the offer of the Cannes trip was for a twelve-week course of treatment valued at approximately $21,000, the market value of thirty prescriptions written by each doctor was $630,000.

In December, 2004, a former regional director for the manufacturer of the AIDS wasting drug pled guilty to three counts of offering to pay illegal remunerations to doctors in his sales territory in connection with his involvement in the kickback scheme. The investigation is continuing.

Now, I would like to quickly add here that under no circumstances are our attorneys attempting to inhibit the professional judgment of medical professionals who prescribe drugs for purposes not yet approved by the FDA. We know that physicians are permitted to prescribe medications for off label uses as they see fit in their medical judgment. A drug manufacturer's dissemination of reprints of medical journal articles, reference textbooks, and independent continuing medical education regarding the safety and efficacy of drugs can be beneficial to health care practitioners and their patients. However, as we saw in the Parke-Davis case, certain companies may seek to vastly increase their market share by promoting their products for off-label purposes, by disseminating false and misleading evidence to support those unapproved uses, and by bestowing gifts and other remuneration on doctors to influence their prescription writing practices. Clearly, the law does not give drug manufacturers carte blanche to promote drugs for off-label uses by any means. Nor does the law create vast exceptions that render the Federal Food. Drug and Cosmetic Act or the Anti-Kickback Statute inapplicable to pharmaceutical manufacturers.

From the cases I have discussed, several lessons have emerged:

- By manipulating and then marketing the "spread" between the Medicare or Medicaid reimbursement rate and the amount the pharmacy or doctor actually pays for a drug, manufacturers are able to induce purchases of their drugs and obtain market share, all at the expense of government programs. Although the Medicare Modernization Act of 2003 addresses this problem on a going forward basis for Medicare Part B reimbursed drugs by using actual sales prices as the operative reimbursement benchmark, the Medicaid program remains vulnerable to such schemes at those at issue in the TAP, Bayer, AstraZeneca, Warrick, and Dey cases.

- Manufacturers have engaged in abuses of the Medicaid Rebate statute, a law that was designed to ensure that the Medicaid program obtains the savings that manufacturers offered to other customers, however those savings were passed along. A close examination of the authorities is timely and warranted by the issues that have arisen in our enforcement efforts.

- By providing free pharmaceuticals to physicians and then instructing them how to bill Medicare and Medicaid for the free products, manufacturers have surreptitiously caused the government to pay for the illegal kickbacks with which they induce physicians to prescribe their drugs. By disguising the true nature of these free products, manufacturers obscure their best prices, facilitate payment of fraudulent claims by these cash strapped programs, and deny Medicaid the full benefit of the drug rebate program. Best price violations that affect Medicaid also directly impact Public Health Service entities, whose prices are based on a derivative formula.

- By inducing physicians to prescribe for uses that have not been approved by the Food and Drug Administration, either by promoting compromised "science" or offering financial incentives, manufacturers are subverting a healthcare system that necessarily relies on the sound medical judgment of practitioners, and perhaps harming the public health

- The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), remains a vital law enforcement tool in assuring that sound medical judgment is not subverted by the payment of inducements that sometimes cause medical professionals to prescribe drugs based on financial considerations and not medical need. Care must be taken to assure that any proposed amendments to the Anti-Kickback Statute designed to accommodate proposed electronic storage of medical records and interoperability of provider recordkeeping systems not result in a weakening of this important weapon in our defense against fraud, waste, and abuse.

The Department, working with its partners at CMS and HHS Office of Inspector General, has taken the lessons learned from these cases and applied them to safeguards for the new Medicare prescription drug benefit. Nevertheless, experience teaches us that manufacturer efforts to place their drugs in particular formularies will take many forms, some of which may be illegal or come at great cost to government health programs.

Conclusion

The cases that I have discussed, and many others, show that the Department has been very active in this area. We have been greatly assisted by industry insiders who have taken advantage of the *qui tam* provisions of the False Claims Act, but we also have been fortunate to be able to work alongside state prosecutors on these complex and difficult cases in a joint effort to protect the integrity of the nation's health system.

As you well know, our Medicaid program is struggling to provide health care to our nation's neediest citizens, and it is doing so at a time when resources are increasingly scarce. We simply cannot afford to let Medicaid be victimized by the schemes that I have discussed here today. Toward that end, the Department of Justice will continue to work with this Committee and its staff to identify problems and work toward formulating solutions.

Again, I thank the Committee for seeking the views of the Department of Justice on these issues. The Committee can be assured that the Department will continue to play a leading role in protecting the healthcare system for fraud and abuse, and will work with this Committee in addressing the myriad issues which I have briefly discussed this morning.

Testimony of Barbara Coulter Edwards
Ohio Medicaid Director
Ohio Department of Job and Family Services

Before the Committee on Finance,
United States Senate

June 28, 2005

Chairman Grassley, Ranking Member Baucus, and members of the committee, thank you for the opportunity to testify before you today. My name is Barbara Coulter Edwards and I have served as the Director of Ohio's Medicaid and SCHIP programs since 1997. I have been asked to participate in your series of hearings by representing the perspective of state Medicaid programs regarding the use of intergovernmental transfers (IGTs) as part of the financing strategies used by states.

Ohio, like many states, uses intergovernmental transfers as a mechanism to facilitate a small portion of Medicaid financing involving public providers of Medicaid services. I am pleased to tell you that CMS has not identified Ohio as a state that may be making improper use of IGTs under Medicaid.

Bottom line, all of the dollars spent in the Ohio Medicaid program are used to provide or support allowable health care services or programs to real Medicaid enrollees: over 2 million low income parents, children, elderly, and disabled Ohioans. I think it's important for the Committee to recognize that states use IGTs or other revenue strategies (e.g., provider taxes, administrative claiming) with Federal approval and under the guidance of explicit federal regulations. These financing strategies are not inappropriate ways for states to accomplish the goals of the Medicaid health plan.

In general, states have built Medicaid programs on what we understood to be the rules of obtaining legitimate federal matching funds. In hindsight, some states may have gone beyond what Congress might have envisioned when the matching program was created, but, frankly, this in response to the entire Medicaid program growing far beyond its early design and role. In most, if not all, cases, states acted with either the explicit approval of federal oversight staff or at least within existing interpretations of federal regulations.

My plea to this Committee is to keep the issue of state financing strategies in the proper context. State efforts to maximize federal matching dollars are not the core problem in and of themselves. They are, in most cases, a symptom of much more fundamental program challenges that state Medicaid Directors must face every day.

State Medicaid Directors are responsible for maintaining the health care safety net that is not only supporting the poorest and sickest citizens but also simultaneously absorbing costs shifted from other parts of the US economy, including:

- Shrinking coverage in employer sponsored health insurance;
- Cost-shifting from Medicare for the poorest elderly and disabled citizens; and
- Middle and upper-income people legally divesting themselves of assets in order to obtain Medicaid long term care coverage while passing private wealth to family members or friends.

In addition to these significant challenges, our states have been in an economic recession. State revenues have been dropping while enrollment in the Medicaid health plan has been soaring. At the same time, Congress and the public have encouraged states to expand eligibility to reach more uninsured children, working adults, and uninsured women with breast and cervical cancer; to provide greater community long term care options for elders and children with disabilities in compliance with the Americans with Disabilities Act; and to support adults with disabilities who want to return to work. Compounding this even further is the impending reality of the aging "baby boomer" population and soaring medical inflation in pharmacy and other costs.

Now imagine managing these challenges in an environment where you cannot "deficit spend," but must instead balance your budget every year.

The reality from the state perspective is that Medicaid spending now accounts for up to 25 percent of most state budgets, exceeding spending on primary and secondary education in some states. Nationwide, Medicaid enrollment has grown over 40 percent during the last five years – an influx of 15 million new beneficiaries. Nevertheless, States have worked hard to keep the rate of Medicaid spending growth below the rate experienced in the private health care sector. Yet, in spite of our success in containing Medicaid spending growth, it has still been double the rate of state revenue growth, a pattern that has now been in place for many years.

In short, state Medicaid programs are caught between the proverbial "rock and a hard place." I suggest to you that using IGTs to maximize federal revenue is a symptom of a much larger issue: the fact that states are struggling with financing the health care costs of the sickest, poorest and most disabled of our citizens. Seventy-five percent of all Medicaid spending is for the 25 percent of enrollees who are aged, blind and disabled. Over 40 percent of total Medicaid spending is for a very small number of enrollees who are already insured through Medicare. And for many states, including Ohio, the new state obligations under the Medicare "Part D" pharmacy program will increase the state cost of providing drugs to the dually eligible population.

State options for controlling Medicaid costs are fairly bleak. Under the program's current configuration, states can control costs by:

- Cutting provider rates (and risk loss of access to needed services);
- Limiting optional benefits (which in many cases are cost effective when compared with mandatory benefits), or

- Eliminating coverage for optional population groups (like women with breast and cervical cancer, SCHIP children, working parents, people whose medical costs cause them to "spend down" into poverty).

Ohio will use all three of these tools to keep the rate of growth in Medicaid spending below four percent annually in our 2006-2007 biennial budget. In addition, we will expand the use of managed care arrangements for low income families and people with disabling conditions, and we will continue to aggressively manage pharmacy costs and utilization. Our savings target over the next two years is almost two billion dollars below the projected baseline. This will achieve more than one billion dollars in federal savings. But sadly, the human and economic cost of these savings will be:

- To increase the number of uninsured adult Ohioans,
- To reduce the scope of dental benefits for 800,000 adults,
- To freeze payments rates for hospitals and nursing homes and,
- For the eighth straight year, to provide no increase in Medicaid payments for primary care physicians and other community providers.

(Almost unbelievably, Ohio's one billion dollars in federal savings over the next two years will not be counted toward the ten billion dollar savings goal established by Congress, because apparently it isn't considered "scoreable" by CBO.)

I want to be clear: I firmly believe that states are obliged to be fiscally responsible in our relationship with the federal Medicaid program. In order to accomplish this goal, state Medicaid Directors ask that we have clear standards, formally promulgated rules that spell out the parameters of our fiscal responsibilities, and consistent application of the rules. There is widespread agreement that if the rules are to be changed, it should not be done mid-stream nor applied retroactively. In addition, if formerly allowable models must be replaced, it is important to recognize that states will need time to transition to alternate funding strategies. The reality is that, for most states, any reduction in federal Medicaid revenue will leave states no choice but to cut programs and services to the vulnerable citizens that Medicaid is intended to serve.

So it is in this context that I urge the members of this Committee not to blame states for somehow causing the financial crisis in this country's Medicaid program. To do so would divert our energy and attention away from the real work of re-conceptualizing and strengthening the viability of this vital health plan that provides health care to 53 million of our poorest, sickest, and most disabled citizens.

The National Association of State Medicaid Directors has joined in support of the National Governor's Association as the NGA has undertaken a serious and bipartisan effort to propose substantive Medicaid reforms. NASMD and the NGA are seeking reforms that will benefit both federal and state taxpayers while continuing to fulfill the purpose of the Medicaid health plan. States also look forward to partnering with Congress and CMS to achieve the goal of creating a sustainable Medicaid program.

Testimony before the Committee on Finance, U.S. Senate

on

Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net

Judith Feder, Ph.D.
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Georgetown Public Policy Institute
Georgetown University

June 29, 2005

Chairman Grassley, Senator Baucus, and members of the Committee, I'm pleased to have the opportunity to testify before you today on long-term care. My testimony will reflect more than twenty-five years of research experience in long-term care, at Georgetown University and, before that, the Urban Institute. Based on that research, my policy conclusions are the following:

- Today, 10 million people of all ages are estimated to need long-term care, close to 40 percent of whom are under the age of 65. Among the roughly 8 million who are at home or in the community, one in five report getting insufficient care, frequently resulting in significant consequences—falling, soiling oneself, or inability to bathe or eat.

- The need for long-term care is unpredictable and, when extensive service is required, financially catastrophic—best dealt with through insurance, rather than personal savings. But the nation lacks a policy that assures people of all ages access to quality long-term care when they need it, without risk of impoverishment.

- Private insurance for long-term care is expanding and will play a growing role in long-term care financing. However, even with improved standards and special "partnerships" with Medicaid, it does nothing for those currently in need, is not promoted as a means to serve the under-65 population and, in the future will be affordable and valuable for only a portion of the older population—most likely, the better off.

- Medicaid is the nation's only safety net for those who require extensive long-term care. Rather than serving as a deterrent to the purchase of private insurance or—as some argue—as an "asset shelter for the rich", it serves overwhelmingly to assure access to care for those least able to afford insurance or care. But its invaluable services become available only when and if people become impoverished; its protections vary substantially across states; and, in most states, it fails to assure access to quality care, especially in people's homes.

- A growing elderly population will mean greater demand on an already significantly stressed Medicaid program, squeezing out states' ability to meet other needs and, at the same time, likely reducing equity and adequacy across states.

- Policy "solutions" that focus only on making Medicaid "meaner" or limiting public obligations for long-term care financing do our nation a disservice. Although individuals and families will always bear significant care-giving and

> financial responsibility, equitably meeting long-term care needs of people of all ages and incomes—throughout the nation—inevitably requires new federal policy and a significant investment of federal funds.

The following will lay out inadequacies in current long-term care financing; the implications of growth in the elderly population for future inadequacies; and the importance of federal policy to sustain and improve long-term care protection. Unless otherwise noted, I am drawing on research from the Georgetown Long-term Care Financing Project, funded by the Robert Wood Johnson Foundation, and available at our web site: **ltc.georgetown.edu.** The opinions I present are, of course, only my own.

People who need extensive assistance with basic tasks of living (like bathing, dressing and eating) face the risk of catastrophic costs and inadequate care. Today, almost 10 million people of all ages need long-term care. Only 1.6 million are in nursing homes. Most people needing long-term, especially younger people, live in the community. Among people not in nursing homes, fully three quarters rely solely on family and friends to provide the assistance they require. The range of needs is considerable—with some people requiring only occasional assistance and others needing a great deal. Intensive family care-giving comes at considerable cost—in employment, health status and quality of life—and may fail to meet care needs. Nationally, one in five people with long-term care needs who are not in nursing homes report "unmet" need, frequently resulting in significant consequences—falling, soiling oneself, or inability to bathe or eat. The cost of paid care exceeds most families' ability to pay. In 2002, the average annual cost of nursing home care exceeded $50,000 and 4 hours per day of home care over a year were estimated to cost $26,000. Clearly, the need for extensive paid long-term care constitutes a catastrophic expense.

The likelihood of needing long-term care is also unpredictable. Although the likelihood increases with age, close to 40 percent of people with long-term care needs are under the age of 65. And the need for care among the elderly varies considerably. Over a lifetime, projections of people currently retiring indicate that about 30 percent are likely to die without ever needing long-term care; fewer than 17 percent are likely to need one year of care or less, and about 20 percent are likely to need care for more than five years.

Because long-term care needs are unpredictable and may be financially catastrophic, insurance is the most appropriate financing strategy. Reliance on savings alone is inefficient and ineffective. People will either save too much or too little to cover expenses. However few people have adequate private or public long-term care insurance. Although sales of private long-term care insurance are growing (the number of policies ever sold more than tripled over the 1990s), only about 6 million people are estimated to currently hold any type of private long-term care insurance. Growing numbers of older people, especially of the segment with significant resources, will create the potential for substantial expansion of that market. But private long-term care insurance policies remain a limited means to spread long-term care risk. Private long-term care insurance

- Is not available to people who already have long-term care needs;
- Is not priced to meet the needs of younger people who are also at risk of needing long-term care;
- Is not affordable to the substantial segment of older persons, now and in the future, with low and modest incomes;

- Limits benefits in dollar terms in order to keep premiums affordable, but therefore leaves policyholders with insufficient protection when they most need care; and
- Lacks the premium stability and benefit adequacy that can assure purchasers who pay premiums year after year that it will protect them against catastrophe.

We need only look at experience in health insurance to recognize that reliance on the individual market—plagued by risk selection, high marketing costs, benefit exclusions, and other problems—for long-term care will be grossly inadequate to assure adequate protection to most people.

Current public policy also falls far short of assuring insurance protection. Medicare, which provides health insurance to many who need long-term care, covers very little long-term care. Its financing for nursing home care and home care is closely tied to the need for acute care and is available for personal care only if skilled services—like nursing and rehabilitation therapy—are also required.

It is Medicaid that provides the nation's long-term care safety net. Most nursing home users who qualify for Medicaid satisfy Medicaid's income and asset eligibility requirements on admission. But 16 percent of elderly nursing home users begin their nursing home stays using their own resources and then become eligible for Medicaid as their assets are exhausted. Because the costs of long-term care are so high relative to most people's income and resources, the opportunity to "spend down" to eligibility—spending virtually all income and assets in order to qualify—is essential to assure access to care.

To qualify for Medicaid nursing home benefits, individuals must reduce their "countable" assets (explicitly exempting certain items—including a home, a car, and funds designated for burial purposes) to $2000 or less and must contribute all their monthly income, with the exception of a "personal needs allowance" of $30 to $90, toward the cost of care. Federal law allows married couples to set aside additional income and assets for a spouse remaining in the community, but many states allow community spouses to keep only the federal minimum levels of income ($1561 per month) and assets ($19,020)—hardly enough assets to assure financial security in retirement.[1]

Some have labeled impoverishment a "fallacy", arguing that the bulk of Medicaid resources go to finance nursing home care for people who could afford to pay for themselves, but who "transfer" their resources in order to qualify for Medicaid benefits. Such exaggeration relies on anecdote, not evidence. As reviewed by my Georgetown University colleague, Ellen O'Brien, the research literature evaluating actual experience reveals the following[2]:

- **Most elderly people lack the financial resources to pay for extended nursing home stays.**

  Among elderly women living alone (those who are most likely to become nursing home residents), median household income is less than $12,000.[3] In 2000, the median net worth—excluding houses—of elderly households was $23,885.[4]

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[1] CMS, "2005 SSI FBR, Resource Limits, 300% Cap, Break Even Points, Spousal Impoverishment Standards," http://www.cms.hhs.gov/medicaid/eligibility/ssi0105.asp.

[2] Ellen O'Brien, "Medicaid's Coverage of Nursing Home Costs: Asset Shelter for the Wealthy or Essential Safety Net?", Issue Brief, Georgetown University Long-term Care Financing Project, May 2005, ltc.georgetown.edu.

[3] Robert Clark and Joseph F. Quinn, *The Economic Status of the Elderly,* Medicare Brief, no.4, Washington, D.C.: National Academy of Social Insurance, 1999. Figures are for 1996. Kaiser Family Foundation analysis of 1999 data indicate little change: elderly women over age 85 (in all living arrangements) had a median income of $15,615.

[4] Shawna Orzechowski and Peter Sepielli, *Net Worth and Asset Ownership of Households: 1998 and 2000,* Current Population Reports, P70-88, Washington, D.C.: U.S. Census Bureau, 2003.

Although, as a group, the elderly have more resources than younger people, financial wealth is very unevenly distributed among them. Assets are almost nonexistent for the elderly in the bottom 30 percent of the wealth distribution, while the top 5 percent have financial wealth (excluding home equity) in excess of $300,000. Elderly people in poor health or with functional impairments likely to create the need for long-term care have even more limited resources than other elderly.[5]

- **The majority of nursing home residents pay in full or in part for their nursing home care.**

Estimates of lifetime nursing home use of the elderly show that 44 percent of nursing home users pay for their nursing home care using only private funds and 16 percent begin as private payers, exhaust their resources and then convert to Medicaid.[6] That 27 percent of elderly nursing home users qualify for Medicaid at admission reflects the limited resources of elderly in the community, not the transfer of assets.

- **Disabled elderly people have too little wealth to warrant hiring an attorney to arrange asset transfer.**

Analysis of resources among people likely to need long-term care reveals that the majority of disabled elderly in the community have such modest resources that they are either financially eligible for Medicaid before entering the nursing home or would quality immediately on admission. Researchers Frank Sloan and Mae Shayne concluded from their analysis that it is a lack of any significant wealth accumulation beyond a home that accounts for the high likelihood of eligibility, not asset transfers.[7]

- **People in nursing homes are more likely to conserve than to exhaust assets.**

Research indicates that nursing home residents spend down to Medicaid at a much lower rate than would be expected given their income and assets. Rather than transferring assets to become Medicaid eligible, some of the elderly may be receiving transfers from children or others, or voluntarily converting housing equity into liquid assets, to extend the period before they become Medicaid eligible—behavior reflecting a "strong aversion to welfare"[8] rather than an effort to qualify.

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[5] Clark and Quinn.

[6] Brenda Spillman and Peter Kemper, "Lifetime Patterns of Payment for Nursing Home Care," *Medical Care* 33, No. 3 (1005): 280-96.

[7] Frank Sloan and Mae Shayne, "Long-Term Care, Medicaid, and the Impoverishment of the Elderly," *Milbank Quarterly* 71, no. 4 (1993):575-99.

[8] Edward C. Norton, "Elderly Assets, Medicaid Policy, and Spend-Down in Nursing Homes," *Review of Income and Wealth* 41, no. 3 (1995): 309-329.

- **Transfers occur far more frequently for tax purposes than for Medicaid eligibility.**

Analysis of trusts indicates that they are far more commonly established by wealthy people seeking to reduce tax burdens and avoid probate than by modest income people seeking to avoid spend-down for nursing home care. Based on their analysis, researchers Donald Taylor, Frank Sloan and Edward Norton concluded that "the vast majority of the group most likely to benefit from the use of trusts to spend down [to Medicaid] did not have one" and found "limited rationale for further public policy efforts designed to limit the use of trusts to achieve spend down because such behavior is rare."[9]

- **Asset transfers among elderly people are both unrelated to and too modest for attaining Medicaid eligibility.**

Analysis of transfers made by the elderly over time out of their accumulated assets show that only 1 in 100 of the elderly gave gifts to their children that would be large enough to qualify them for Medicaid nursing home coverage.[10] Among "middle class" elderly at risk of spending down to Medicaid if they need a nursing home, an estimated 29 percent gave gifts to children or grandchildren of $500 or more; the typical gift was $2000 and the average gift was $5000. The largest transfers were made by those who perceived themselves as least likely to be entering a nursing home in the next five years.[11] Overall, the most frequent asset transfers have been among elderly people with assets exceeding the estate tax filing threshold rather than for other elderly. Indeed, transfers have been least likely among elderly people with modest assets who are in poor or declining health—leading researchers to conclude that these elderly are actually holding onto assets (not transferring them), in order to pay for care.[12]

- **Transfers aimed at establishing Medicaid eligibility are not significant contributors to Medicaid costs.**

A 1993 GAO review of 400 Medicaid applications for nursing home assistance in Massachusetts (a state thought to have a high level of estate planning) found that 1 in 8 applicants had transferred assets averaging $46,000. Half of these applicants, however, were denied eligibility.[13] Cost estimates of state proposals to restrict asset transfers produce only modest Medicaid savings—e.g. 0.6 percent of Medicaid nursing home spending in Massachusetts; 1.4 percent in Connecticut.[14] OMB estimates of the savings from the President's proposal to tighten current law amount to less than 0.2 percent of total federal Medicaid spending between 2006 and 2015.[15]

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[9] Donald Taylor, Frank Sloan, and Edward Norton, "Formation of Trusts and Spend Down to Medicaid," *Journal of Gerontology: Social Sciences,* 54B, no. 4 (1999):S194-201.

[10] Taylor, Sloan and Norton.

[11] William F. Bassett, "Medicaid's Nursing Home Coverage and Asset Transfers," working paper, Board of Governors of the Federal Reserve System, March 26, 2004.

[12] Jonathon Feinstein and Chih-Chin Ho, "Elderly Asset Management and Health," in *Rethinking Estate and Gift Taxation,* ed. William G. Gale, James R. Hines, and Joel Slemrod, Washinton, D.C.: Brookings Institution Press, 2001.

[13] U.S. General Accounting Office, *Medicaid Estate Planning,* GAO/HRD-93-29R (Washington, D.C.:GAO, 1993).

- **Medicaid does not serve as a significant barrier either to savings or to the purchase of private long-term care insurance.**

Analysis of savings behavior among the elderly indicates that elderly people most likely to qualify for Medicaid reduced savings more slowly than wealthy elderly, as they aged;[16] and that people who expect to need long-term care have higher savings than those who don't.[17] Finally, analysis of actual purchases of private long-term care insurance found no impact on purchase decisions among older workers and found the slight impact on purchasers over age 70 too small to explain the very low proportion of elderly holding policies.[18].

The evidence indicates that the real problem with Medicaid is not its use or abuse by people who do not need its protections; rather it is insufficient protection for people who do. Despite Medicaid's essential role, its protections differ considerably from what we think of as "insurance". Medicaid does not protect people against financial catastrophe; it finances services only after catastrophe strikes. Further, Medicaid's services fall far short of meeting the needs and preferences of people who need care. Medicaid's benefits focus overwhelmingly on nursing home care—an important service for some, but not the home care services preferred by people of all ages. In the last decade, Medicaid home care spending has increased from 14% to 29% of Medicaid's total long-term care spending. But nursing homes still absorb the lion's share of Medicaid's support for long-term care.

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[14] CMS, "Waiver Research and Demonstration Projects," http://cms.hhs.gov/medicaid/1115.

[15] Office of Management and Budget (OMB), *Major Savings and Reforms in the President's 2006 Budget,* Washington, D.C., OMB, 2005,188, http://whitehouse.gov/omb/budget/fy2006/pdf/savings.pdf and Ellen O'Brien.

[16] Frank Sloan, Thomas Hoerger and Gabriel Picone, "Effects of Strategic Behavior and Public Subsidies on Families' Savings and Long-Term Care Decisions," in *Long-term Care: Economic Issues and Policy Solutions,* ed. Roland Eisen and Frank A. Sloan, (Boston, MA: Kluwer Academic Publishers, 1996).

[17] Anthony Webb, *The Impact of the Cost of Long-Term Care on the Saving of the Elderly,* (New York: International Longevity Center, 2001).

[18] Frank A. Sloan and Edward C. Norton, "Adverse Selection, Bequests, Crowding Out and Private Demand for Insurance: Evidence from the Long-Term Care Insurance Market, *Journal of Risk and Uncertainty* 15, no.3,1997: 201-219.

Medicaid protection also varies considerably from state to state. As a federal-state matching program, Medicaid gives states the primary role in defining the scope of eligibility and benefits. A recent Urban Institute analysis emphasized the resulting variation across states in service availability as a source of both inequity and inadequacy in our financing system. In an examination of 1998 spending in 13 states, long-term care dollars per aged, blind, or disabled enrollee in the highest spending states (New York and Minnesota) were about 4 times greater than in the lowest (Alabama, Mississippi)—a differential even greater than that found for Medicaid's health insurance spending for low income people.

Both our own research and that conducted by the Government Accountability Office tells us that differences in state policies have enormous consequences for people who need long-term care. Studies comparing access for individuals with very similar needs in different communities show that people served in one community get little or no service in another. Georgetown research finds that the same person found financially eligible or sufficiently impaired to receive Medicaid services in one state might not be eligible for Medicaid in another—and, if found eligible, might receive a very different mix or frequency of service. And a comparison of use of paid services in 6 states finds almost twice the incidence of unmet need (56%) in the state with the smallest share of people likely to receive paid services as in the state with the largest (31 %).

This variation—as well as ups and downs in the availability of benefits over time—undoubtedly reflects variation in states' willingness and ability to finance costly long-term care services. The recent recession demonstrated the impact on states of changes in their economies and the vulnerability of Medicaid recipients to states' reactions. In 2001, Medicaid accounted for 15 % of state spending, with long-term care responsible for 35% of the total. Virtually all states were cutting their Medicaid spending as budget pressures struck, endangering access either for low income people needing health insurance, older or disabled people needing long-term care, or both.

In sum, under current policy, neither public nor private insurance protects people against the risk of long-term care. Despite Medicaid's important role as a safety net, the overall result for people who need care is catastrophic expenses, limited access to service, and care needs going unmet.

Given inequities and inadequacies in our current approach for long-term care, it is no wonder that we are concerned about the future, when a far larger proportion of the nation's population will be over age 65 than are today. Experts disagree on whether disability rates among older people in the future will be the same as or lower than they are today. But even if the proportion of older people with disabilities declines, the larger number of older people will likely mean a larger number of older people will need long-term care in the future than need it today. The population aged 85 and older, who are most likely to have long-term care needs, is likely to double by 2030 and quadruple by 2050.

States will vary in the aging of their populations—with resulting differences in the demand for long-term care and the ability of their working-aged population to support it. To identify future demands on Medicaid, a Georgetown study examined census data on the ratio of elderly people to working-age adults between 2002 and 2025. Nationally, this ratio changes from about one to five (one person over age 65 for every 5.2 people of working age) in 2002 to one to three—an increase of about 66 percent. But the changes differ across states, with some states well below the national average (e.g. California, Connecticut, D.C., Massachusetts) and others, far above. In many states, the ratio increases by more than three quarters and in a few (e.g. Colorado, Utah, and Oregon), it more than doubles. All states will be challenged to meet increased long-term care needs.

States are already struggling with Medicaid's fiscal demands, which challenge their ability to meet equally pressing needs in education and other areas. And state revenue capacity varies considerably. If current policies persist, pressure to make difficult tradeoffs will only get stronger. In the future, states with bigger increases in the elderly-to-worker ratio will face the greatest pressure. And, since many of the states with above average changes currently spend relatively little per worker on Medicaid long-term care, there is a strong likelihood that in the future, long-term care financing will be even less equitable and less adequate across the nation than it is today.

What's needed for a different future is public policy action. Developing better policy requires an assessment of options to assure access to affordable quality long-term care and to distribute financing equitably between individuals who need long-term care and their families, on the one hand, and the rest of federal and state taxpayers, on the other. Consideration of federal budgetary implications is an important part of the assessment process. But allowing budgetary constraints to drive that process distorts the nation's policy choices. Last April's CBO report on long-term care financing did precisely that. Explicitly focusing on the achievement of only one policy goal—alleviation of "pressure" on the federal budget—the report treated as legitimate only policy options with the potential to reduce federal spending, without regard to the consequences for people in need.

From this perspective, the report's first set of policy options—cutting back already inadequate Medicaid and Medicare protection—is not surprising. But its implications are nevertheless horrifying. CBO straightforwardly states that such action could reduce the number of people dependent on public programs—a fairly obvious conclusion. But it presents no evidence that people inappropriately rely on Medicaid today; and no evidence that savings or private long-term care insurance would provide adequate protection if Medicaid were made more restrictive for the future. Indeed CBO explicitly recognizes that this approach implies greater burdens on family and friends, greater difficulty in obtaining care, and greater bad debt for long-term care providers. If the policy goal is—

as it should be—to improve care and distribute costs equitably, such cutbacks seem unconscionable, not desirable.

Proposals aimed at tightening existing restrictions on resource transfers may similarly do ~~more harm than good.~~ ~~Claims that Medicaid serves as an asset shelter for the~~ wealthy rather than a safety net are simply not supported by the evidence. Broad action to tighten those restrictions would frighten some elderly people out of contributing to their grandchildren's education, helping their adult children overcome economic hurdles, or making donations to their favorite charities. Unexpected penalties for people who do make gifts would require enforcement actions against unsuspecting families and would likely leave providers without payment. Policy that targets specific abuses—where there is evidence they exist—makes sense. But penalizing all modest income older people and their families for just living their lives cannot be justified.

The CBO report's second set of options to alleviate fiscal pressure aim to "improve the functioning of the market for private long-term care insurance"—a strategy that is less likely than public cutbacks to reduce access but still unlikely to significantly improve either access or equity. Standardizing long-term care insurance policies might facilitate consumers' ability to make choices in the marketplace and improve the adequacy of private long-term care insurance. But, as CBO notes, standards that improve policies would likely increase insurance premiums. The result might be better protection for those who can afford private insurance—a worthy goal, but it is highly unlikely to be an increase in the numbers of people willing or able to buy insurance.

CBO's consideration of so-called "partnerships for long-term care"—which would allow benefits paid by private insurance to offset (or protect) assets for Medicaid users who purchase approved private long-term care insurance policies—also reveals this strategy's limitations. These partnerships have been advocated as a means to save Medicaid money by preventing "spend-down" and asset transfers. The hope is that allowing the purchase of asset protection, along with insurance, will encourage modest income people to purchase private long-term care insurance. Experience with these policies in four states has produced only limited purchases, primarily among higher income people, and has affected too few people for too short a period to assess its impact on Medicaid spending (Alexis Ahlstrom, Emily Clements, Anne Tumlinson and Jeanne Lambrew, "The Long-Term Care Partnership Program: Issues and Options", Pew Charitable Trusts' Retirement Security Project, George Washington University and The Brookings Institution, December 2004). The partnership has contributed to improved standards for long-term care insurance policies and more partnership policies are being sold to more modest income people as the standards that apply to them are also applied to the broader market. However, as CBO notes, if these policies simply substitute for policies individuals would otherwise have purchased or increase the likelihood of using long-term care services, they may eventually increase rather than decrease Medicaid expenditures. From the budgetary perspective, advocacy of reliance on Medicaid to essentially subsidize private long-term care insurance alongside promotion of budget legislation to curtail federal Medicaid contributions seems both disingenuous and risky. Further, from the broader equity perspective, targeting private long-term care insurance to modest income people seems questionable. The purchase of a limited long-term care insurance policy could easily absorb close to 10 percent of median income for a couple aged 60—a substantial expenditure for a cohort acknowledged as woefully unprepared to meet the basic income needs of retirement.

Even more questionable are proposed tax preferences for private long-term care insurance. CBO does not analyze these proposals, perhaps because they would clearly increase rather than decrease public expenditures. Nevertheless, they are consistently on the policy agenda, despite the likelihood that they will be poorly targeted to improve insurance protection. Experience with health insurance tells us that such credits are likely to primarily benefit those who would have purchased long-term care insurance even in the absence of credits—substituting public for private dollars—and, as currently proposed, are not even designed to reach the substantial portion of older and younger Americans with low and modest incomes.

Indeed, the whole focus on reducing public spending and promoting private insurance ignores the public responsibility to address for all Americans what should be our fundamental policy choice: do we want to live in a society in which we assure affordable access to long-term care for people who need it or in a society in which we leave people in need to manage as best they can on their own?

There is little question that to address both current and future long-term care needs requires not a decreased but an increased commitment of public resources—and, to be adequate and effective in all states—federal resources. Expanded public financing for long-term care could take a variety of forms and by no means need eliminate private contributions. One option, modeled on Social Security, would be to provide everyone access to a "basic" or "limited" long-term care benefit, supplemented by private insurance purchases for the better-off and enhanced public protection for the low income population. Another option would be establishment of a public "floor" of asset protection—a national program assuring everyone access to affordable quality long-term care—at home as well as in the nursing home—without having to give up all their life savings as Medicaid requires today. The asset floor could be set to allow people who worked hard all their lives to keep their homes and modest assets, while allowing the better off to purchase private long-term care insurance to protect greater assets. Either public/private combination could not only better protect people in need; it could also provide substantial relief to states to focus on health insurance, education and other pressing needs—relief that governors have explicitly requested by calling on the federal government to bear the costs of Medicare/Medicaid "dual eligibles". Because Medicaid serves the neediest population and, in the current budgetary environment is at risk, my highest priority for expenditure of the next federal dollar would be responding to this call (along with supporting more home care and better quality care) with more federal dollars to Medicaid.

Some will undoubtedly characterize proposals like these as “unaffordable”, given the fiscal demands of Medicare and Social Security and the current federal budget deficit. But that deficit reflects policy choices. I would far rather see expenditure of the next federal dollar devoted to enhanced Medicaid long-term care financing than to tax credits for long-term care or tax cuts in general. Indeed, the estate tax is especially appropriate for long-term care financing: taxing everyone’s estate at certain levels, to provide reasonable estate protection for those unlucky enough to need long-term care.

As we look to the future, examination of the choices being made by other nations of the world is instructive. Analysis by the Organization for Economic Cooperation and Development (OECD) of long-term care policy in 19 OECD countries (presented at the June 2004 research meeting of AcademyHealth) found that the number of countries with universal public protection for long-term care (Germany, Japan and others) is growing. Public protection, they report, does not imply the absence of private obligations (cost sharing and out-of-pocket spending), nor does it imply unlimited service or exploding costs. Rather, in general, it reflects a “fairer” balance between public and private financing—relating personal contributions to ability to pay and targeting benefits to the population in greatest need. Many of these nations have substantially larger proportions of elderly than the U.S. does today and therefore can be instructive to us as we adjust to an aging society.

Clearly, we will face choices in that adjustment. If we are to be the caring society I believe we wish ourselves to be, we too will move in the direction of greater risk-sharing and equity by adopting the national policy and committing the federal resources which that will require.

U.S. SENATE COMMITTEE ON
Finance
SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN
http://finance.senate.gov

Opening Statement of U.S. Senator Chuck Grassley of Iowa
Chairman, Senate Committee on Finance
Hearing, Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net
Wednesday, June 29, 2005

Thank you for joining us for day two of this important hearing. Yesterday we learned about some significant problems with the Medicaid program. At the conclusion of yesterday's hearing, we discussed efforts to correct them and to help reduce the impact that fraud, waste and abuse is having on the sustainability of this important program.

Today we will have two panels again to discuss more problems with fraud, waste and abuse in Medicaid. Our first panel is here to discuss prescription drug pricing, an issue that has been a central health care policy concern the past few years. Medicaid paid nearly $30 billion for prescription drugs in FY 2004 and the cost of both health care and drugs will continue to rise.

Prescription drug pricing is a very complex area of Medicaid. As recent lawsuits and settlements have shown, drug pricing is an area of Medicaid with significant levels of waste, fraud and abuse. For example, between 2001 and 2004, the Department of Justice and the states' attorneys general recovered nearly $2.5 billion from various pharmaceutical companies. This amount includes both Medicare and Medicaid. However, these settlements are evidence of systemic, industry-wide problems that needs to be addressed.

The cases and settlements often speak for themselves: Pfizer $430 million, Schering-Plough $345 million, TAP Pharmaceuticals $875 million. And the list goes on. Most of these settlements resulted from cases filed under the federal False Claims Act. As a principal author of the 1986 amendments to the False Claims Act, I have worked to ensure that its provisions are faithfully enforced. Whistleblowers frequently risk everything when bringing false claims cases. I am pleased that our first witness of the day is a brave woman who will discuss her experiences as a whistleblower.

Our whistleblower will be followed by testimony from the Department of Justice and the Office of the Inspector General. We will hear testimony on federal oversight of the Medicaid drug pricing program, including drug pricing fraud and drug company settlements. The Office of the Inspector General will present its recent work, which will show the potential for significant savings in the Medicaid program. The drug pricing panel will also include a representative from the Texas Attorney General's Office, who will provide a state perspective on problems with prescription drug pricing. Finally we have a representative from the Pharmaceutical Research and Manufacturers of America who is here today to discuss the industry's perspective on prescription drug pricing.

Today's second panel will address another trend in the Medicaid program, the transferring of assets to qualify for Medicaid coverage. Six witnesses today will discuss asset transfers in the Medicaid program, including testimony from a long-term care facility representative and a resident of that facility. In addition, the Congressional Research Service will provide its background research on asset transfers and Medicaid estate planning and recovery. A representative from the Oregon Department of Human Services will testify about estate recovery efforts in Oregon. And we will also hear from the long term care industry. Specifically a representative from MetLife is here. MetLife is member of the American Council of Life Insurers. Finally we will hear from the Dean of the Public Policy Institute at Georgetown University and will view a short education video clip on asset transfers.

As I indicated yesterday, this hearing is about identifying problems and fixing them in order to maintain Medicaid as a strong safety net.

Exhibit 1

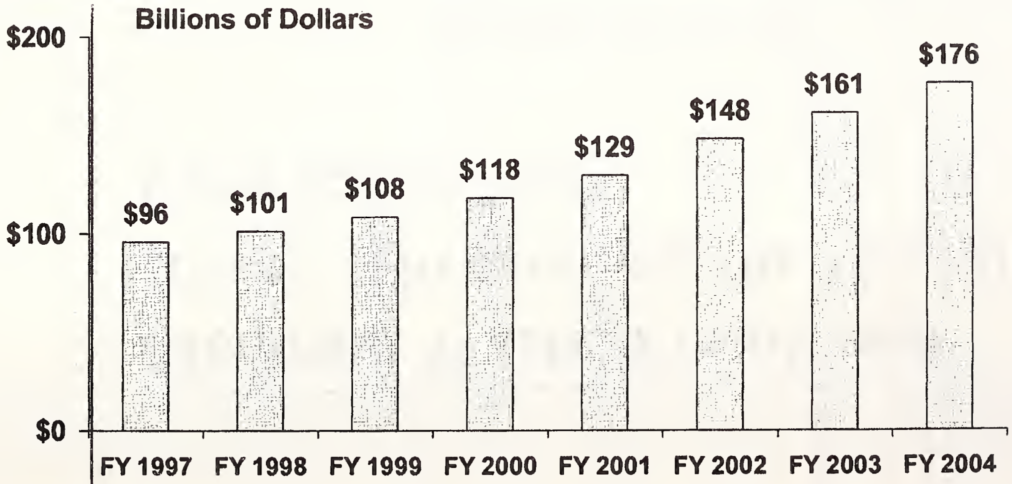
Medicaid Waste, Fraud, and Abuse: Threatening the Health Care Safety Net

Hearing Before the
Senate Committee on Finance
June 28-29, 2005

Exhibit 2

Federal Medicaid Outlays

FY 1997 – FY 2004



SOURCE: Congress of the United States, Congressional Budget Office. *The Budget and Economic Outlook: Fiscal Years 2006-2015*. January 2005. Table F-9, page 142.

Exhibit 3

State Participants in Medicaid Fraud and Abuse Control

- **State Medicaid Agencies**
    - Responsible for day-to-day state Medicaid program operations
    - Must comply with federal requirements governing fraud and abuse control
    - May carry out responsibilities by contracting with other state agencies or private entities
    - Refers suspected cases of fraud and abuse to MFCUs
- **Medicaid Fraud Control Units (MFCUs)**
    - Investigate and prosecute Medicaid provider fraud and patient abuse and neglect
    - Must be a single, identifiable entity of state government that is separate from the state Medicaid agency
    - Most are located within offices of State Attorneys General

Exhibit 4

Federal Participants in Medicaid Fraud and Abuse Control

- **Dept. of Health and Human Services (HHS), Center for Medicare and Medicaid Services (CMS)**
  - Provides oversight of state Medicaid program activities and compliance with fraud and abuse control requirements.
- **Dept. of Health and Human Services, Office of the Inspector General (HHS/OIG)**
  - Provide oversight of state MFCUs
  - Undertakes fraud and abuse detection and prevention efforts (through investigations, audits, evaluations, issuance of program recommendations)
  - Participates in prosecutions and settlements of Medicaid fraud cases
  - Maintains a list of providers who have been excluded from participation in federal health care programs due to fraud conviction or other reason

Exhibit 5

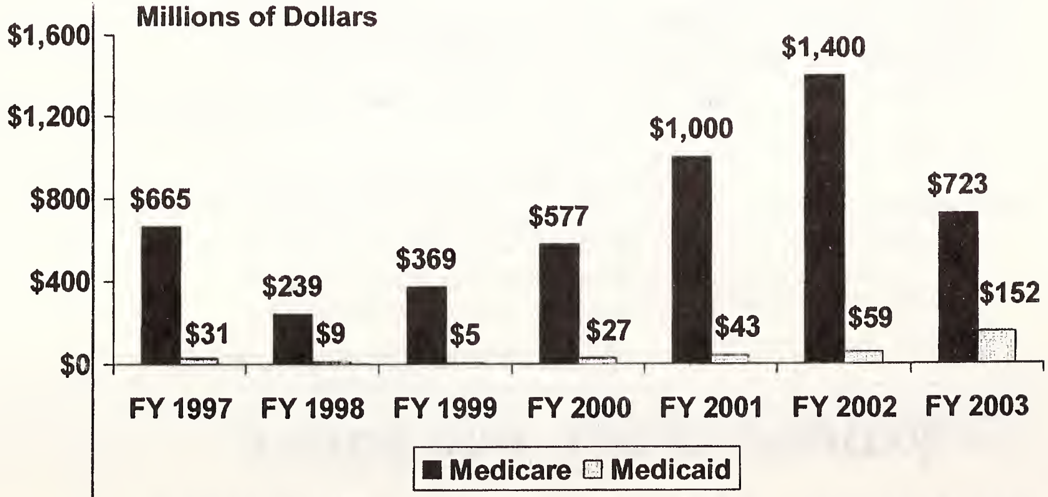
Federal Participants in Medicaid Fraud and Abuse Control

- **Department of Justice (DOJ)**
  - Responsible for civil and criminal prosecutions of federal health care crimes, including Medicaid fraud
  - Cases are referred from many sources, including the FBI, HHS/OIG, state MFCUs, other law enforcement agencies, and *qui tam* (whistleblower) complaints
- **Federal Bureau of Investigation (FBI)**
  - Primary investigative agency involved in health care fraud that has jurisdiction over both federal and private insurance programs
  - Coordinates efforts through investigative partnerships with other federal agencies, including HHS/OIG

Exhibit 6

Federal Medicare and Medicaid Fraud Recoveries

FY 1997 – FY 2003



SOURCE: U.S. Department of Justice and DHHS Office of the Inspector General, Health Care Fraud and Abuse Control Program, Annual Reports, 1998-2003. www.usdoj.gov/dag/pubdoc.html.

Exhibit 1 – Day 2

Medicaid Waste, Fraud, and Abuse: Threatening the Health Care Safety Net

Hearing Before the
Senate Committee on Finance
June 28-29, 2005

Exhibit 2 – Day 2

Total Medicaid Spending and Medicaid Prescription Drug Spending –

Selected Years in billions of dollars

Year	Total Medicaid [a]	Average Annual % Change	Medicaid Prescription Drug Spending [b]	Average Annual % Change	Medicaid Drugs as % of Total Medicaid
1990	$ 69.8	–	$ 4.6	–	6.3%
1995	151.7	16.8%	8.4	12.7%	5.5%
2000	194.7	5.1%	16.6	14.7%	8.5%
2004 [c]	280.3	9.5%	30.3	16.2%	10.8%

Notes:

[a] Does not include administrative costs

[b] Does not include prescription drugs paid through capitated arrangements, obtained directly from physicians or bundled in claims for other services, and rebates have been subtracted from totals.

[c] 2004 data are preliminary and incomplete.

SOURCE: CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*

Exhibit 3 – Day 2

Negative Signals:
Prescription Drug Lawsuits
Total Recoveries 2001-2005

- Total Recoveries (both Medicare and Medicaid)
  - $2.458 Billion
- Total Medicaid Recovery
  - $948 Million
    - Federal Medicaid Share = $534.9 Million
    - State Medicaid Share = $413.1 Million

SOURCE: Taxpayers Against Fraud Education Fund (TAFEF)

Exhibit 4 – Day 2

Negative Signals:
Prescription Drug Lawsuits
Settlements and Recoveries – 2001-2005

- Bayer Corp. (Bayer I) – Jan. 23, 2001
  - Total Recovery = $355 Million
- TAP Pharmaceuticals – Jan. 3, 2001
  - Total Recovery = $875 Million
- Pfizer, Inc. (Pfizer I) – Oct. 28, 2002
  - Total Recover = $49 Million
- Bayer Corp. (Bayer II) – April 16, 2003
  - Total Recovery = $257 Million

SOURCE: Taxpayers Against Fraud Education Fund (TAFEF)

Exhibit 5 – Day 2

Negative Signals:
Prescription Drug Lawsuits (cont.)
Settlements and Recoveries – 2001-2005

- GlaxoSmithKline – April 16, 2003
  - Total Recovery = $88 Million
- Dey Pharmaceuticals – June 11, 2003
  - Total Recovery = $18 Million
- AstraZeneca – June 20, 2003
  - Total Recover = $355 Million
- Schering-Plough Corp. (Schering-Plough I) May 13, 2004
  - Total Recovery = $27 Million

SOURCE: Taxpayers Against Fraud Education Fund (TAFEF)

Exhibit 6 – Day 2

Negative Signals:
Prescription Drug Lawsuits (cont.)
Settlements and Recoveries – 2001-2005

- Pfizer, Inc (Pfizer II) – May 13, 2004
  - Total Recovery = $430 Million
- Schering-Plough Corp. (Schering-Plough II)
  - July 29, 2004
  - Total Recovery = $355.5 Million

SOURCE: Taxpayers Against Fraud Education Fund (TAFEF)

Exhibit 7 – Day 2

Examples of Pharmaceutical Pricing Scams

Committed by Manufacturers

- Overstating AWP
- Overstating "best price"
  - "Nominal" pricing
  - Generally disregarding value of discounts/incentives
- Offering kickbacks or other incentives to maintain products on certain formularies
- Manufacturers offering illegal remuneration in various forms to induce purchase of drugs
  - E.g. educational grants, travel, entertainment...etc.

SOURCE: Congressional Research Service (CRS) review of Inspector General Reports, testimony and related lawsuits.

Exhibit 8 – Day 2

Examples of Pharmaceutical Pricing Scams

Committed by Physicians and Pharmacists

- Submitting claims for products that had been provided by manufacturers free of charge
- Partially filling prescriptions and billing Medicaid for the full prescription

SOURCE: Congressional Research Service (CRS) review of Inspector General Reports, testimony and related lawsuits.

Exhibit 9 – Day 2

Asset Transfers

Potential Savings as a Percentage of Medicaid Long Term Care Expenditures

- Total Medicaid Expenditures on Long Term Care[1] =$290.2 Billion / 5 years
  - Total Savings of .5% = $1.5 Billion
  - Total Savings of 1.0% = $2.9 Billion
  - Total Savings of 2.0% = $5.8 Billion
  - Total Savings of 3.0% = $8.7 Billion

1. Long Term Care Expenditures for elderly beneficiaries only–Does not include LTC for non-elderly beneficiaries

Medicaid:
Federal and State Oversight

Testimony of:
Daniel R. Levinson, Inspector General

Hearing Before:
Senate Committee on Finance
Charles E. Grassley, Chairman

June 28, 2005

Office of Inspector General
U.S. Department of Health and Human Services

Testimony of:
Daniel R. Levinson, Inspector General
U.S. Department of Health and Human Services

Good Morning Mr. Chairman and Members of the Committee. On behalf of the Office of Inspector General, we appreciate the Committee's devoting these two days to address important issues associated with the Medicaid program. We are pleased to have the opportunity to provide three witnesses during this hearing to discuss these issues.

My testimony describes the roles of our office, the Centers for Medicare & Medicaid Services (CMS), and the States in meeting the challenges of overseeing the Medicaid program. I will discuss issues associated with identifying and resolving fraud. I will also discuss some specific program vulnerabilities identified in our work, which we believe merit attention and corrective action.

FEDERAL AND STATE PARTNERSHIP TO SHARE COSTS

A major responsibility of our office is to ensure that the Federal share of Medicaid is paid correctly and appropriately. Because Medicaid is a matching program, improper payments by States to providers always cause corresponding improper Federal payments. However, because the Federal Government does not routinely examine individual provider claims, inappropriate claims by States for a Federal share are not always easily identified. The Federal share of Medicaid outlays in fiscal year (FY) 2004 exceeded $176 billion and is expected to exceed $192 billion in FY 2006. In FY 2004, 43.7 million federally eligible children and adults were covered by Medicaid, and the number of federally eligible enrollees is expected to exceed 46 million in FY 2006.[1]

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, and States may also have managed care arrangements. Most States have at least some portion of their beneficiaries in managed care. In total, about half of the Medicaid population nationwide is enrolled in managed care, with the other half remaining in fee-for-service. Within federally imposed upper limits and specific restrictions, States have broad discretion in determining the payment methodology and payment rate for services.

The Federal Government pays a share of each State's Medicaid program costs. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. With certain exceptions, Federal payments to States for medical assistance have no set limit. Rather, the Federal Government matches (at FMAP rates) the States' outlays for covered items and services and also matches, at the appropriate administrative rate (typically 50 percent), all necessary and proper administrative costs.

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[1] CMS FY 2006 Budget in Brief.

IDENTIFYING AND RESOLVING IMPROPER PAYMENTS AND FRAUD

Controlling the cost of Medicaid involves both identifying and resolving improper and fraudulent payments and improving the program through our audits, program evaluations, investigations, and the use of statutory authorities to sanction providers who have engaged in fraud. My testimony addresses each of these matters.

Types of Improper Payments

While some improper payments are fraudulent, we believe most are not. Although we have no data on the amount of improper payments or the percentage of improper payments that are fraudulent, our sense is that the vast majority of providers are honest in their billings for Medicaid reimbursement. However, improper payments may arise because of clerical errors, misinterpretations of rules, or poor record keeping. Improper payments include both overpayments and underpayments and are generally adjusted or collected administratively. Common categories of improper payments include:

- Unsupported Services. Providers must maintain records that are sufficient to justify diagnoses, admissions, treatments performed, and continued care. When the records are insufficient or missing, claims reviewers cannot determine whether services billed were actually provided to beneficiaries, the extent of the services, or their medical necessity. An item or service that is not adequately documented should not be billed to Medicaid.

- Medically Unnecessary Services. The documentation in the medical records leads to an informed decision by a claims reviewer that the medical services or products received were not medically necessary.

- Incorrect Coding. Standard coding systems are used to bill State Medicaid programs for services provided. In a coding review, medical reviewers determine whether the documentation submitted by providers supports a lower or higher reimbursement code than was actually submitted.

- Noncovered Costs or Services. These are costs or services that Medicaid will not reimburse because they do not meet the State's Medicaid reimbursement rules and regulations. A Federal share would not be paid for such costs or services.

- Third-Party Liability. Medicaid inappropriately pays claims, and is generally not reimbursed, for beneficiaries who have other sources of payment, such as private insurance.

Types of Fraudulent Activities

Some of the billings and related practices that are determined to be improper are also determined to be fraudulent. Fraudulent behavior may arise when enrollment procedures for providers are inadequate, internal controls are deficient, payment rates are excessive (inviting fraudulent and abusive behavior), or when especially vulnerable beneficiaries can be exploited easily. The types of fraudulent schemes we see in the Medicaid program in many ways mirror those in Medicare:

- Billing for Services Not Provided. This is one of the most common types of fraud. Examples include a provider who knowingly bills Medicaid for a treatment or procedure that was not actually performed, such as blood tests when no samples were drawn or x-rays that were not taken.

- False Cost Reports. A nursing home owner or hospital administrator may intentionally include inappropriate expenses not related to patient care on cost reports submitted to Medicaid.

- Illegal Remunerations (Kickbacks). A provider (such as a nursing home operator) may conspire with another health care provider (such as a physician or ambulance company) to share a part of the monetary reimbursement the health care provider receives in exchange for the referral of patients. Such kickbacks include not only cash, but vacation trips, automobiles, or other items of value. The practice results in encouraging unnecessary tests and services to be performed for the purpose of generating additional income to both the referring source and the provider of the service.

As I will outline below, the responsibility for detecting improper payments and investigating and prosecuting fraud and abuse in the Medicaid program is shared between the Federal and State governments.

Role of the Centers for Medicare & Medicaid Services

In 1996, CMS established a program integrity group to address fraud and abuse issues within the Medicaid and Medicare programs. This group conducts and oversees many projects that are intended to reduce program fraud. June 1997 marked the beginning of a national intergovernmental initiative to reduce Medicaid fraud and abuse. Accomplishments include presenting intergovernmental executive seminars and issuing a comprehensive plan for program integrity; guidelines for addressing fraud and abuse in Medicaid managed care; and a resource guide of State fraud and abuse systems. This initiative is now known as the Medicaid Alliance for Program Safeguards. Among other activities, the Alliance is conducting a series of program integrity reviews at State Medicaid agencies designed to help States strengthen their program integrity operations to prevent, identify, and resolve improper and fraudulent Medicaid payments. CMS is also leading the development of a methodology to measure the national and State-level Medicaid program error rate. Another effort, called the Medi-Medi pilot, compares Medicare and Medicaid billing data to identify aberrant provider billings, such as situations in which both programs are billed for the same items and services.

Role of State Medicaid Agencies in Identifying Fraud

Each of the State Medicaid agencies is required to have a program integrity (PI) unit or other office that conducts preliminary investigations of suspected fraud and refers cases to the State's Medicaid Fraud Control Unit or other appropriate law enforcement officials for a full investigation. In addition, each of the State Medicaid agencies has a data system, called the Surveillance and Utilization Review Subsystem (SURS), which is a part of the State's Medicaid Management Information System. In smaller States, the SURS units may also operate the PI units, conducting preliminary reviews of Medicaid fraud or abuse and referring appropriate cases for a full investigation. In all States, SURS applies automated post-payment screens to Medicaid claims to identify aberrant billing patterns that may indicate fraud or provider abuse. When potential fraud cases are detected, the State agency refers the cases to the State's Medicaid Fraud Control Units.

Role of State Medicaid Fraud Control Units

State Medicaid Fraud Control Units are part of the State Attorney General's office or other State agency that is separate and distinct from the Medicaid State agency. The purpose of the Units is to investigate and prosecute Medicaid provider fraud, patient abuse or neglect, and fraud in the administration of the program.

As noted above, by regulation, States' Medicaid agencies are required to refer appropriate cases to the Medicaid Fraud Control Units for a full investigation. We continuously receive comments from the Medicaid Fraud Control Units indicating that Medicaid agency referrals are inadequate in many States. Such statements demonstrate that our findings in a 1996 inspection, in which we determined that the number and percentage of suspected fraud referrals to the Medicaid Fraud Control Units from the SURS units had declined during the preceding 10 years, continue to be a problem. At the time, officials at the State Medicaid Fraud Control Units were divided in their opinions as to the extent and quality of SURS development of fraud allegations and computer edits. Our anecdotal experience is that the lack of referrals is still viewed as a serious problem in many States.

In addition to receiving leads from the State Medicaid Agency, the Medicaid Fraud Control Units receive leads from other sources, including other State and Federal law enforcement agencies, whistleblowers, beneficiaries, concerned citizens, the press, and legislative bodies. If a matter that comes to the attention of a Medicaid Fraud Control Unit is determined to be an improper payment that does not warrant a fraud investigation, the matter is referred to the State Medicaid agency to pursue recovery of the improperly paid amount. Otherwise, the State Medicaid Fraud Control Unit fully investigates and ensures appropriate resolution, including prosecution. Outcomes may include restitution, fines, penalties, and corporate integrity agreements, as well as incarceration.

Financial fraud. Over the years, the Units have recovered hundreds of millions of dollars. The following chart shows the Units' funding and statistical accomplishments for the past 10 years. Recoveries include settlements or court-ordered restitution, fines, and penalties.

Medicaid Fraud Control Units
Federal Expenditures and Related Federal/State Statistical Accomplishments

Year	Federal Expenditure*	Federal/State Recoveries	Convictions
2004	$131,086,294	$572,585,322	1,160
2003	119,831,000	268,481,661	1,096
2002	116,979,079	288,315,524	1,147
2001	106,699,505	252,585,423	1,002
2000	95,979,000	180,941,872	970
1999	89,703,745	88,738,327	886
1998	85,793,887	83,625,633	937
1997	80,557,146	147,642,299	871
1996	77,453,688	57,347,248	753
1995	73,258,421	88,560,361	684

* Amount of Federal grant award that was received by the Units.

Patient Abuse. While not the focus of this hearing, investigating patient abuse and neglect in Medicaid-funded facilities and in board and care facilities is another major responsibility for the State Medicaid Fraud Control Units. In most instances, these cases do not generate monetary returns, but are critical to the provision of high quality and appropriate care, especially for our Nation's frail elderly.

Role of OIG in Overseeing the State Medicaid Fraud Control Units

The State Medicaid Fraud Control Units grant program was originally managed within CMS (then the Health Care Financing Administration (HCFA)). Because the Units' activities were determined to be more closely related to the OIG's investigative function than to HCFA's program management role, in 1979, the grant management and oversight responsibilities for the program were transferred to the Office of Inspector General. The States are reimbursed for the operation of the Units at a rate of 90 percent of costs for the first 3 years after the Unit's initial certification by OIG and 75 percent thereafter. During FY 2005, OIG will administer approximately $149.4 million in grant funds to the Units.

The OIG's responsibilities for oversight of the funding and operating standards of the Medicaid Fraud Control Units include monitoring their overall performance and productivity and ensuring that they devote their full-time efforts to Medicaid fraud and patient abuse, rather than being deployed to other matters.

Our duties also include the initial certification and yearly recertification of the Units. Regulations require the Units to submit an application to our office with an annual report and a budget request. The Unit's application, annual report, budget, and quarterly statistical reports are reviewed to determine if the Units are in conformance with performance standards that were developed jointly by OIG and the Units themselves. Another mechanism our office uses to assess the Units' performance is feedback from the State Medicaid Agency and our own Office of Investigations field offices. Our staff is now conducting between 8 and 14 on-site inspections annually. We maintain ongoing communication with individual State Units and the National Association of Medicaid Fraud Control Units related to the interpretation of program regulations and other policy issues.

Our office, the Medicaid Fraud Control Units, and other law enforcement agencies work closely together on fraud cases and other activities, and these partnerships have greatly enhanced OIG's ability to carry out its mission. Generally, the State Medicaid Fraud Control Units focus on Medicaid fraud, and OIG's own investigators focus on Medicare fraud. However, many providers who are involved in illegal activities are found to be defrauding both programs at the same time. Therefore, an investigation of either program may reveal fraud in the other program as well. In FY 2004, OIG conducted joint investigations with the Units on 314 criminal cases and 91 civil cases and achieved 64 convictions. The amount of civil recoveries by the Medicaid Fraud Control Units has been increasing since 1999, and at least two of the States have designated special sub-units to develop civil fraud cases.

One area of increasing activity by the Medicaid Fraud Control Units is in civil litigation. Under a 1999 policy interpretation by our office, the Units are expected to investigate any potential criminal violations first and must then consider if there is a civil fraud case. Civil fraud cases may be pursued under State laws, including false claims acts in those States that have such laws, or under the Federal Civil False Claims Act, which has been a longstanding and powerful tool in the fight against health care fraud and abuse. Under the False Claims Act, the Department of Justice may pursue False Claims Act penalties and damages. Under our own administrative sanction authorities, OIG may pursue civil monetary penalties and exclusion of providers for violations of health care laws.

OIG, along with the Department of Justice and other Federal law enforcement agencies, has achieved major successes in using the False Claims Act, and in particular its qui tam[2] provisions, in pursing fraud in both the Medicare and Medicaid programs. Many of these cases have been brought against pharmaceutical companies, as will be further explained in testimony tomorrow by Regional Inspector General Robert Vito.

OIG and State Medicaid Audit Partnerships

In addition to our oversight of and assistance to the State Medicaid Fraud Control Units, our office has initiated a number of partnerships with State auditors. Several years ago, OIG began an initiative to work more closely with State auditors in reviewing the Medicaid program. A partnership plan was created as a way to provide broader coverage of the Medicaid program by partnering with State auditors, State Medicaid agencies, and State internal audit groups. The level of involvement of each partner is flexible and can vary depending on specific situations and available resources. In one instance, the OIG role may entail the sharing of our methodology and experience in examining similar Medicare issues. In other cases, we may join together with State teams to audit suspected problems.

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[2] The qui tam provisions allow whistle blowers to bring suit under the False Claims Act seeking recoveries against defrauders of government programs. The Department of Justice (DOJ) determines whether or not to intervene in the case; the case may proceed without DOJ. In either case, the whistle blower, or "relator," may share in any later recoveries, whether ordered by a court, or as the result of a settlement.

Issues examined in this partnership initiative include Medicaid outpatient prescription drugs, unbundling of clinical laboratory services, outpatient nonphysician services already included as an inpatient charge, excessive costs related to hospital transfers, excessive payments for durable medical equipment, acquisition costs for Medicaid drugs, and program issues related to managed care.

This partnership approach provides broader coverage of the Medicaid program and maximizes the impact of scarce audit resources by both the Federal and State audit sectors. To date, these joint efforts have been developed in 25 States. Completed reports have identified $263 million in Federal and State savings and included recommendations for improvement in internal controls and computer systems operations.

Role of OIG in Identifying Improper Payments

Improper or fraudulent payments result in a substantial drain on State and Federal funds. Therefore, our office directly conducts a large number of Medicaid audits on our own initiative or at the request of CMS, the Department, or Congress. Intended to identify improper payments, these audits not only reveal questionable billings, but sometimes also expose fraud, program management deficiencies, or weaknesses and loopholes in program rules. When we question Medicaid payments, we notify CMS of our findings, and, if CMS agrees that the questioned payments were improper, it recovers the Federal share from the States. Occasionally, CMS does not concur with our findings and makes a decision not to recover some or all of the Federal share of the amounts we questioned. If possible fraud is found, our criminal investigators review the matter and determine whether to open an investigation. Our auditors may also assist in the ongoing criminal investigations being conducted by our office or other law enforcement agencies.

IMPROVING THE MEDICAID PROGRAM

In addition to identifying misspent funds, OIG's audits are always intended to bring about program improvements and thus help reduce the cost of providing necessary services to Medicaid beneficiaries. OIG also has an active evaluation function focused on finding ways to improve the program. These evaluations focus on whether the Medicaid program is managed properly and pays a fair price in the health care marketplace.

Over the years, our audits and evaluations have addressed numerous vulnerabilities in the Medicaid program. We provide a complete list of our unimplemented recommendations in our "Red Book"[3] and "Orange Book"[4] that are published annually on our Web site. Below are some of the more notable topics that we believe still merit attention and require corrective action.

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[3] The Red Book is the OIG's Cost Saver Handbook.

[4] The Orange Book is the OIG's Program and Management Improvement Recommendations.

Following are examples of audits and evaluations of Medicaid practices and policies:

- OIG audited enhanced payments made to local public hospitals and nursing facilities under upper payment limit (UPL) rules in several States and found that billions of Medicaid dollars were, in effect, at risk of being diverted from their intended purpose. These practices disproportionately shift the cost of Medicaid to the Federal Government, contrary to Federal and State cost-sharing principles. In accordance with our early work, regulatory improvements were made. However, additional changes are needed to curb ongoing abuses. Recent OIG work at individual nursing facilities has demonstrated that States still divert enhanced funding from poorly functioning facilities to other purposes, with negative implications for quality of care. This work will be described by our Assistant Inspector General for CMS Audits, George Reeb, during the next panel.

- OIG's audits and evaluations of Medicaid drug pricing issues over the past decade have clearly demonstrated that Medicaid pays too much for prescription drugs and that implementing a variety of options could improve States' programs and lead to substantial savings. In accordance with our findings, States have made a number of changes in their reimbursement amounts and methods, but more improvements are needed. At tomorrow's hearing, our Regional Inspector General from Philadelphia, Robert Vito, will review our body of work and introduce new reports regarding the potential impact if Medicaid were to change its basis of reimbursement from certain published prices (including the commonly used average wholesale price) to a sales-based price. The ultimate goal of this work is to help ensure that Medicaid's prescription drug programs pay a fair price that reasonably reflects actual acquisition costs.

- OIG recently reviewed internal controls in 48 States and the District of Columbia to determine whether drug rebates are collected properly. A national rollup report of findings and recommendations is being prepared with the goal of encouraging States to improve their rebate collection systems. Of the States audited, only four had no weaknesses in accountability and internal controls over their drug rebate programs. For the remaining States and the District of Columbia, we identified the following weaknesses: (1) unreliable information submitted to CMS on Form CMS 64.9R (37 States), (2) improper accounting for interest on late rebate payments (27 States), (3) an inadequate rebate collection system (17 States), and (4) an inadequate dispute resolution and collection process (15 States).

- In 2000, OIG issued three reports on evaluations of Medicaid's program safeguards. The first report described activities that occur before claims for payment are generated; the second described methods to ensure that submitted claims are properly adjudicated; and the third contained information about post-payment safeguards. The reports were issued in concert with CMS's efforts to invigorate the States' interest in better program integrity practices.

- Several years ago, OIG studied tax and donation schemes and the practice of transferring assets to attain eligibility for Medicaid long term care. The OIG's work helped bring about regulatory and statutory improvements at that time. Now, the Administration and Congress are revisiting these policy areas to determine how they can be strengthened to further control program costs. At the request of CMS, OIG is in the process of conducting a new review of Medicaid provider tax issues.

- OIG conducted a third party liability evaluation that estimated that $367 million is at risk of being lost when Medicaid pays pharmacy claims for beneficiaries who have other insurance. Even though Medicaid is the payer of last resort, Medicaid sometimes pays the pharmacy claim and then attempts to recover the payment from the third-party health insurance in an approach referred to as "pay and chase." Almost three-quarters of States reported that third parties refuse to process or pay pharmacy claims that Medicaid has already paid.

CONCLUSION

In conclusion, Mr. Chairman, our office will continue to devote considerable resources to auditing and evaluating the Medicaid program to identify payment issues and errors, to improve the program, and, when necessary, to pursue appropriate law enforcement actions to recover funds paid to fraudulent providers. We also will continue to collaborate with CMS, State auditors, the State Medicaid Fraud Control Units, the Department of Justice, and other intergovernmental enforcement agencies to identify and resolve fraud and abuse. The management and fiscal integrity of the Medicaid program is one of OIG's top priorities. I appreciate this opportunity to testify, and I welcome your questions.

Senate Testimony 6/29/2005

Good morning Senators, I'm Beatrice Manning, one of the whistleblowers in the recent government settlement with Schering Plough resulting in a $50 million criminal fine and a $292 million civil penalty. I worked at Schering for slightly over five years (Spring 1997- Spring 2002). During the four final years of my employment I was a whistleblower. I have a doctorate in sociology and came to Schering Plough after having been academia and having had a 10-year career in public health. I also worked a short time as a consultant to another drug company and for a major insurer.

While at Schering Plough I was the manager of opportunity identification at a wholly-owned subsidiary, Integrated Therapeutics Group (ITG). Now I am a student at Andover Newton Theological School with a specialty in ethics.

Schering Plough used an intricate scheme to cheat Medicaid out of hundreds of millions, if not billions, of dollars. Schering Plough evaded its responsibility to charge the US government and its beneficiaries the lowest price it charged the private sector, i.e., the best price as required by federal law. Most of the scheme was carried out using the subsidiary, ITG, which in retrospect I believe was created specifically to commit fraud. The scheme, which centered on Schering's blockbuster drug Claritin, had three major prongs that served as "kick-backs" in disguise. These kick-backs resulted in Claritin actually costing many insurers and HMOs an equal amount or less compared to Allegra, its major competitor. The lower amount, however, was not reflected in Schering's calculation of best-price, which it is required to give to Medicaid and other government programs.

First, the subsidiary provided free or well-below-cost health management services to HMOs that put Claritin on formulary. These services were not provided to Medicaid clients, including Medicaid clients enrolled in those same HMOs. The value of these services was not included in the best-price calculation Schering used to establish Medicaid pricing. ITG would sign a contract with the HMO and this contract would be totally separate from the cash rebate contracts that Schering Plough, itself would sign with insurers. Medicaid auditors would review the rebate contracts with Schering Plough (not the subsidiary, ITG) and thus would never see the additional "kick-backs" Schering gave through its subsidiary. I invite your attention to Exhibit A, a draft memo from Linda Zhou, who was then head of Schering's Contracts and Pricing division. In this memo, she is making the "business case" for further investment into ITG's computing capacity. On page 3, under Roman numeral I, she states, "ITG's services complement and enhance Schering's pharmaceutical products and meaningfully differentiate them from the competition. Thus, they provide our primary means of implementing the strategy to *compete on a basis other than price.*" On the next page under the section of "Increased Profitability" she indicates that this has allowed Schering to decrease its discounts (by which best-price is determined) from 23% to 17% and right above we see that Schering as early as 1989 was increasing its sales (net of any rebates) by over $50M per year as a result of these health management contracts. Also note that throughout this memo there is no indication that health plans are paying anything for these health management services. The return on investment is calculated in Table 2 by dividing increased sales of Schering drugs by ITG's operation expenses, showing a nearly 4:1 return on investment for Schering. In essence, ITG's health management services to for-profit HMOs and other health insurers was being financed by the higher prices Medicaid was paying for Claritin.

I invite your attention to Exhibit B, showing the relationship between ITG and Schering Plough. Roch Doliveux is both the CEO of ITG and the Sr. VP of Managed Care within the Schering organization; he reports directly to Raul Cesan, who was then the CEO of Schering laboratories. The subsidiary, ITG, was tied to Schering at the highest levels.

Beyond health management services ITG also used "partnership fees" in its relationships with Pharmaceutical Benefits Managers (PBMs), which are often used by HMOs and other insurers to manage the pharmacy benefits part of coverage packages. ITG would engage with PBMs, who had large data sets, to conduct analyses for developing pharmacy metrics to be used in treating respiratory patients. They would be analyses that Schering already knew the outcome of, e.g., better treatment of allergies leads to fewer office visits for upper respiratory infections, or, better treatment of allergies leads to decreased emergency room use and hospital admissions for asthma patients. I want to be specific here – these analyses were real and the results were real and I believe they indicated appropriate treatment for patients, however, "partnership fees" to do such studies were well above their actual cost. As the fees increased significantly above costs (compared to what had been paid to consulting firms), I and others were asked by management to indicate that these fees appropriately reflected effort and value to ITG. When I and the others refused, were we "counseled" and questioned about our loyalty to the company.

I invite you to examine Exhibit C an internal document showing Schering-Plough's flow of pharmaceuticals and cash. Two points are important if you look at the bottom of this flow chart. "Schering-Plough provides the HMO with free or underpriced services (Health Management)" and, flowing to the right and up, "rebate check and partnership fees to PBMs." ITG was used for both of these activities and they would not appear on Schering's books which were audited by Medicaid.

Finally, Schering used a law designed to allow pharmaceutical companies to give drugs free or at nominal cost to entities such as public hospitals and inner-city and rural health clinics serving low- income populations without these "gifts" entering into the best-price calculation. Schering, however, used this provision to "give" nominally price drugs, which were off-patent and low profit to for-profit insurers, and HMOs to equalize the difference between the "price" of Claritin and the "price" of Allegra. The last page of Exhibit D shows an example of this calculation. I suggest closing this loop hole.

I want now to turn to some key points that may explain why this scheme and others like it could continue so long without detection. First, work was organized such that it was quite difficult for any one person to put together the entire scheme, unless one was working at the very top levels of the organization. The Medicaid pricing unit was located in an entirely different location, had no contact with ITG, and wouldn't have seen ITG contracts. Even within ITG, work was intentionally "silo'ed." I would have done outcomes analysis, showing for instance, that treating allergies results in fewer hospitalizations for asthma, and I might have presented these findings to HMOs and PBMs, but I wasn't involved in structuring the health management "deals" between ITG and those entities. In reality, we were doing good work -- ITG's health management programs continually won awards and were recognized by firms like JD Powers as top programs. The work I did was being presented at medical meetings and being published in refereed medical journals. Frankly, for the average person it's hard to believe that your good work is in reality nothing more than a bribe.

Secondly, I want to stress that this scheme did not result from public corruption or inadequate Medicaid auditing. In essence, two sets of books were being kept.

Third, HMOs were not innocent participants in this scheme. There were HMOs, e.g., some of the best rated by US News & World Report -- Harvard, Tufts, Kaiser who would not accept health management services as a trade for formulary access. Those honest HMOs were disadvantaged by this scheme, having either to develop their own, or purchase, health management programs.

Fourth, when the investigation got "hot" there were serious attempts to force the blame down. Two to three years into the investigation, we started getting "compliance training" and surveys and tests asking such questions as, "Do you know of any product purchase being contingent on any other product?" Interestingly none of the training or questionnaires addressed "best price," the major violation. At best they would say that "best price" issues should be referred to the legal department. This would essentially be the kiss of death for employees in the field – sales would not be made and much of field force salary was based on sales. The corporate culture was designed to encourage individuals not to question actions. Examples for me include "counseling" sessions with my boss, where I would be told things like, "Bea, your job is not to point out problems. Legal can do enough of that by itself. Your job is to come up with solutions."

Finally, I believe there is still a considerable lack of information regarding Qui Tam and how to file Qui Tam complaints. We heard about this mechanism from our lawyer, Neil Mullin, whom we had engaged because we were being retaliated against for siding with a secretary who was being sexually harassed by our boss. Not surprisingly, he had provided much of the brains behind this scheme and was being protected. Had it not been for Neil's knowledge of Qui Tam and his willingness to take on this case, it probably would not have been filed. I admire Senator Grassley's action after our settlement was announced, when he asked drug companies to make sure their employees are aware of this option. Another group that I also think is important to inform is labor lawyers. Based on our experience, when serious and well substantiated cases are not being addressed, there are often other issues going on within the organization.

I want to spend just a few moments on my experience using Qui Tam. First, I want to say I always advise people against taking action if they are just doing it for the money. The thought of some potential money some time will not get you through what will in all probability be years of investigation with minimal feedback about what is even going on. Drug companies have major resources to throw at such cases. Over the six years of our case, we estimate that Schering was spending at least $50,000/day on legal expenses. Individuals, the US Attorney's office, and private attorneys cannot match that monetary commitment. Those issues aside, I want to state publicly that I admire the persistence of the US attorneys, Margaret (Peg) Hutchenson and Marilyn May, who handled our case. Without their persistence and Neil

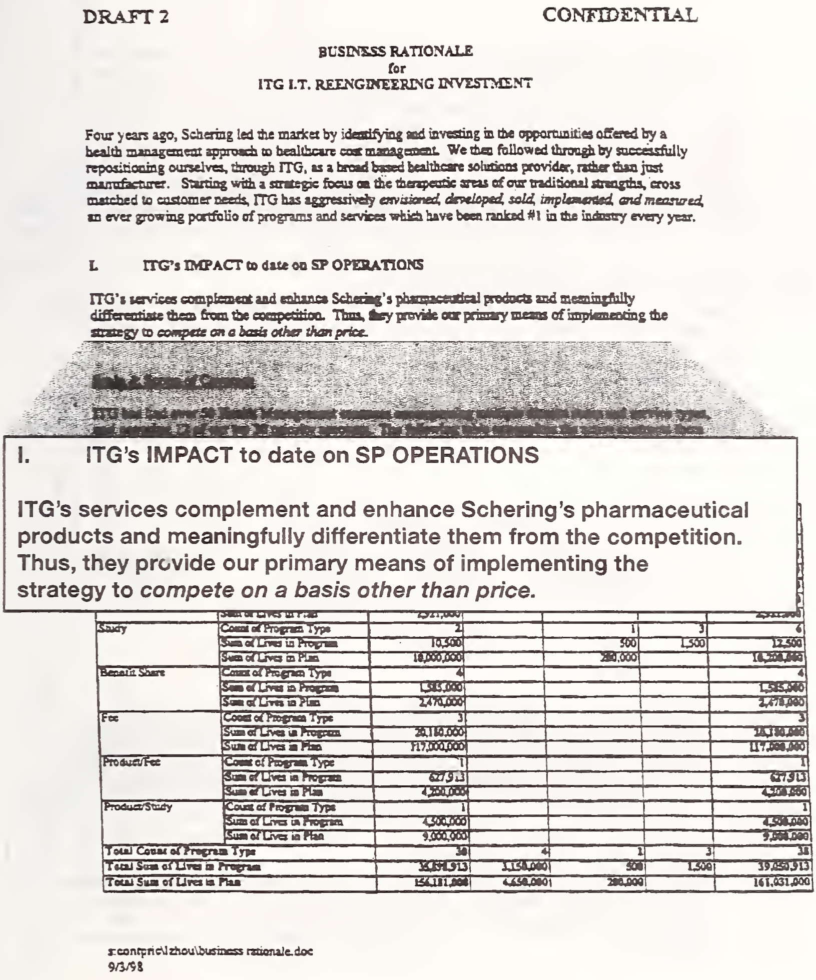
Mullin's, Steve Engelmyer's, and Imogene Hughes', I do not believe that this case would have had a successful conclusion. It is our impression that, at the federal level, Medicaid was not consistently helpful to the US attorney's office.

Despite the successful outcome of our case, I do have some regrets, which I think have policy implications. Nobody was held personally responsible for their actions. No executives were pursued either civilly or criminally. While our settlement was one of the largest Medicaid settlements ever, to some extent $350 million dollars plus legal expenses was the cost of doing business for Schering. While Claritin was still on patent there were several years where Schering collected revenue exceeding $2 billion per year from Claritin sales. To be a more serious deterrent, Qui Tam must result in higher settlements and executives must be held personally responsible. I respect Senator Grassley's bill to review settlements as a step in that direction.

Finally, I want to stress the importance of Qui Tam in decreasing fraud. The intricate bookkeeping, siloed work environment, and the use of subsidiaries have made it virtually impossible to catch fraud through auditing alone. I also think that government needs to consider more extreme administrative controls in dealing with drug companies such as fee schedules similar to those used in relation to doctors and hospitals. This industry has become arrogant, essentially lawless, and definitely amoral in regard to its dealings with government and for that matter, patients.

I thank you for inviting me to share my thoughts and experiences with you.

Qui Tam Relator – Exhibit A



DRAFT 2 **CONFIDENTIAL**

BUSINESS RATIONALE
for
ITG I.T. REENGINEERING INVESTMENT

Four years ago, Schering led the market by identifying and investing in the opportunities offered by a health management approach to healthcare cost management. We then followed through by successfully repositioning ourselves, through ITG, as a broad based healthcare solutions provider, rather than just manufacturer. Starting with a strategic focus on the therapeutic areas of our traditional strengths, cross matched to customer needs, ITG has aggressively *envisioned, developed, sold, implemented, and measured,* an ever growing portfolio of programs and services which have been ranked #1 in the industry every year.

I. ITG's IMPACT to date on SP OPERATIONS

ITG's services complement and enhance Schering's pharmaceutical products and meaningfully differentiate them from the competition. Thus, they provide our primary means of implementing the strategy to *compete on a basis other than price.*

[illegible]

I. ITG's IMPACT to date on SP OPERATIONS

ITG's services complement and enhance Schering's pharmaceutical products and meaningfully differentiate them from the competition. Thus, they provide our primary means of implementing the strategy to *compete on a basis other than price.*

	Sum of Lives in Plan	2,521,000				2,521,000
Study	Count of Program Type	2		1	3	6
	Sum of Lives in Program	10,500		500	1,500	12,500
	Sum of Lives in Plan	18,000,000		200,000		18,200,000
Benefit Share	Count of Program Type	4				4
	Sum of Lives in Program	1,585,000				1,585,000
	Sum of Lives in Plan	2,470,000				2,470,000
Fee	Count of Program Type	3				3
	Sum of Lives in Program	20,180,000				20,180,000
	Sum of Lives in Plan	117,000,000				117,000,000
Product/Fee	Count of Program Type	1				1
	Sum of Lives in Program	627,913				627,913
	Sum of Lives in Plan	4,200,000				4,200,000
Product/Study	Count of Program Type	1				1
	Sum of Lives in Program	4,500,000				4,500,000
	Sum of Lives in Plan	9,000,000				9,000,000
Total Count of Program Type		30	4	1	3	38
Total Sum of Lives in Program		35,898,913	3,150,000	500	1,500	39,050,913
Total Sum of Lives in Plan		156,181,000	4,650,000	200,000		161,031,000

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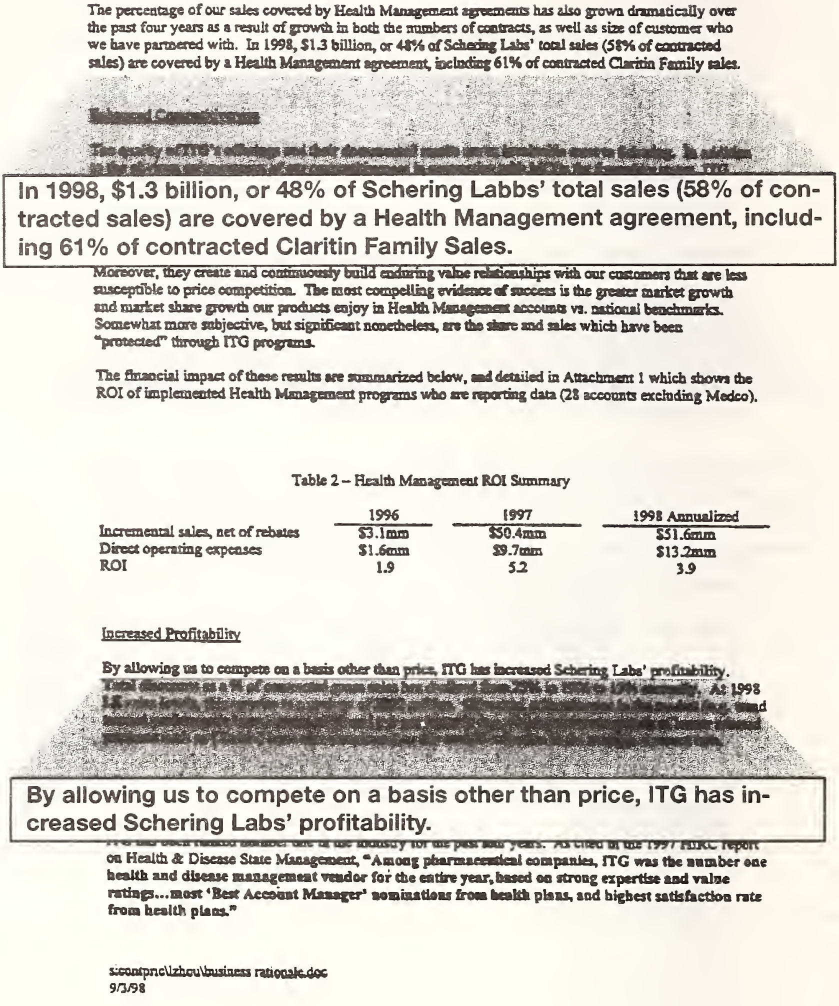
9/3/98

Qui Tam Relator – Exhibit A



The percentage of our sales covered by Health Management agreements has also grown dramatically over the past four years as a result of growth in both the numbers of contracts, as well as size of customer who we have partnered with. In 1998, $1.3 billion, or 48% of Schering Labs' total sales (58% of contracted sales) are covered by a Health Management agreement, including 61% of contracted Claritin Family sales.

[illegible]

[illegible]

In 1998, $1.3 billion, or 48% of Schering Labbs' total sales (58% of contracted sales) are covered by a Health Management agreement, including 61% of contracted Claritin Family Sales.

Moreover, they create and continuously build enduring value relationships with our customers that are less susceptible to price competition. The most compelling evidence of success is the greater market growth and market share growth our products enjoy in Health Management accounts vs. national benchmarks. Somewhat more subjective, but significant nonetheless, are the share and sales which have been "protected" through ITG programs.

The financial impact of these results are summarized below, and detailed in Attachment 1 which shows the ROI of implemented Health Management programs who are reporting data (28 accounts excluding Medco).

Table 2 – Health Management ROI Summary

	1996	1997	1998 Annualized
Incremental sales, net of rebates	$3.1mm	$50.4mm	$51.6mm
Direct operating expenses	$1.6mm	$9.7mm	$13.2mm
ROI	1.9	5.2	3.9

Increased Profitability

By allowing us to compete on a basis other than price, ITG has increased Schering Labs' profitability. [illegible] At 1998 [illegible]

By allowing us to compete on a basis other than price, ITG has increased Schering Labs' profitability.

[illegible] As cited in the 1997 HIRC report on Health & Disease State Management, "Among pharmaceutical companies, ITG was the number one health and disease management vendor for the entire year, based on strong expertise and value ratings...most 'Best Account Manager' nominations from health plans, and highest satisfaction rate from health plans."

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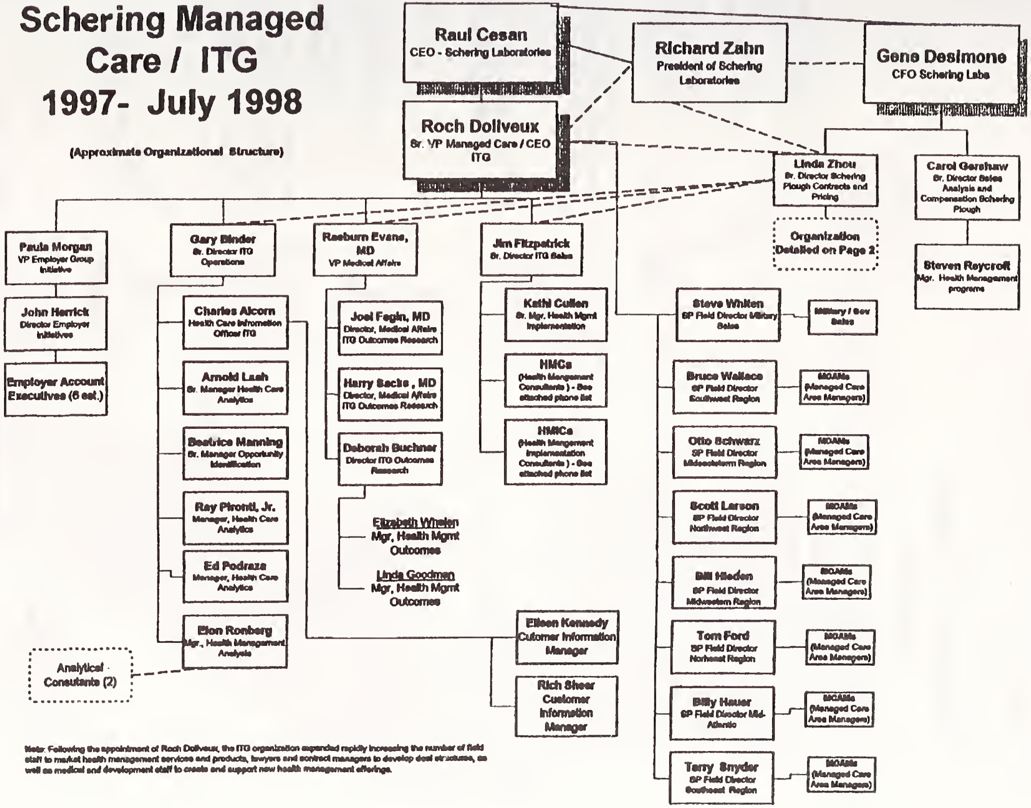
Qui Tam Relator – Exhibit B

Schering Managed Care / ITG 1997- July 1998

(Approximate Organizational Structure)



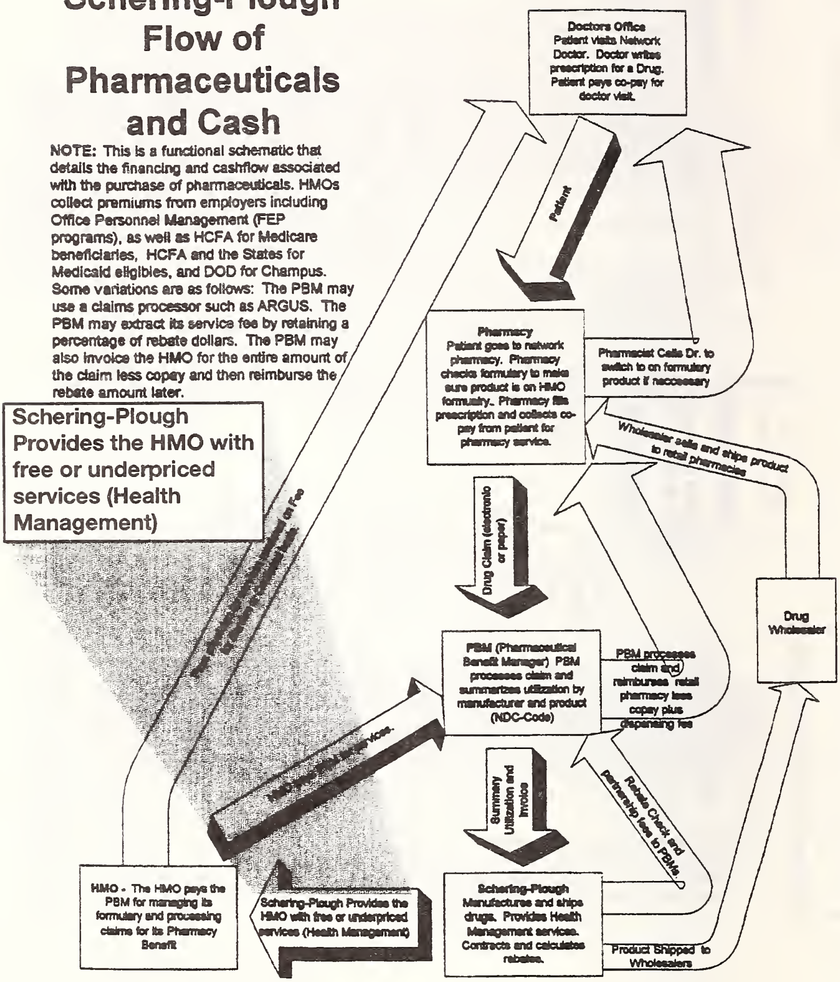
Raul Cesan
CEO - Schering Laboratories
Richard Zahn
President of Schering Laboratories
Gene Desimone
CFO Schering Labs
Roch Dolliveux
Sr. VP Managed Care / CEO ITG
Linda Zhou
Sr. Director Schering Plough Contracts and Pricing
Organization Detailed on Page 2
Carol Gershaw
Sr. Director Sales Analysis and Compensation Schering Plough
Steven Reycroft
Mgr. Health Management programs
Paula Morgan
VP Employer Group Initiative
John Herrick
Director Employer Initiatives
Employer Account Executives (6 est.)
Gary Binder
Sr. Director ITG Operations
Charles Alcorn
Health Care Information Officer ITG
Arnold Lash
Sr. Manager Health Care Analytics
Beatrice Manning
Sr. Manager Opportunity Identification
Ray Pironti, Jr.
Manager, Health Care Analytics
Ed Podraza
Manager, Health Care Analytics
Elon Ronberg
Mgr., Health Management Analysis
Analytical Consutants (2)
Raeburn Evans, MD
VP Medical Affairs
Joel Fegin, MD
Director, Medical Affairs ITG Outcomes Research
Harry Sacks , MD
Director, Medical Affairs ITG Outcomes Research
Deborah Buchner
Director ITG Outcomes Research
Elizabeth Whelen
Mgr, Health Mgmt Outcomes
Linda Goodman
Mgr, Health Mgmt Outcomes
Jim Fitzpatrick
Sr. Director ITG Sales
Kathi Cullen
Sr. Mgr. Health Mgmt Implementation
HMCs
(Health Mangement Consultants) - See attached phone list
HMICs
(Health Mangement Implementation Consultants) - See attached phone list
Eileen Kennedy
Cutomer Information Manager
Rich Sheer
Customer Information Manager
Steve Whiten
SP Field Director Military Sales
Military / Gov Sales
Bruce Wallace
SP Field Director Southwest Region
MCAMs (Managed Care Area Managers)
Otto Schwarz
SP Field Director Mideastern Region
MCAMs (Managed Care Area Managers)
Scott Larson
SP Field Director Northwest Region
MCAMs (Managed Care Area Managers)
Bill Hieden
SP Field Director Midwestern Region
MCAMs (Managed Care Area Managers)
Tom Ford
SP Field Director Norheast Region
MCAMs (Managed Care Area Managers)
Billy Hauer
SP Field Director Mid-Atlantic
MCAMs (Managed Care Area Managers)
Terry Snyder
SP Field Director Southeast Region
MCAMs (Managed Care Area Managers)

Note: Following the appointment of Roch Dolliveux, the ITG organization expanded rapidly increasing the number of field staff to market health management services and products, lawyers and contract managers to develop deal structures, as well as medical and development staff to create and support new health management offerings.

Qui Tam Relator – Exhibit C

Schering-Plough Flow of Pharmaceuticals and Cash

NOTE: This is a functional schematic that details the financing and cashflow associated with the purchase of pharmaceuticals. HMOs collect premiums from employers including Office Personnel Management (FEP programs), as well as HCFA for Medicare beneficiaries, HCFA and the States for Medicaid eligibles, and DOD for Champus. Some variations are as follows: The PBM may use a claims processor such as ARGUS. The PBM may extract its service fee by retaining a percentage of rebate dollars. The PBM may also invoice the HMO for the entire amount of the claim less copay and then reimburse the rebate amount later.


Doctors Office
Patient visits Network Doctor. Doctor writes prescription for a Drug. Patient pays co-pay for doctor visit.
Patient
Pharmacy
Patient goes to network pharmacy. Pharmacy checks formulary to make sure product is on HMO formulary.. Pharmacy fills prescription and collects co-pay from patient for pharmacy service.
Pharmacist Calls Dr. to switch to on formulary product if neccessary
Wholesaler sells and ships product to retail pharmacies
Schering-Plough Provides the HMO with free or underpriced services (Health Management)
Drug Claim (electronic or paper)
Drug Wholesaler
PBM (Pharmaceutical Benefit Manager) PBM processes claim and summarizes utilization by manufacturer and product (NDC-Code)
PBM processes claim and reimburses retail pharmacy less copay plus dispensing fee
Fee
Summary Utilization and Invoice
Rebate Check and partnership fees to PBMs.
HMO - The HMO pays the PBM for managing its formulary and processing claims for its Pharmacy Benefit
Schering-Plough Provides the HMO with free or underpriced services (Health Management)
Schering-Plough
Manufactures and ships drugs. Provides Health Management services. Contracts and calculates rebates.
Product Shipped to Wholesalers

Qui Tam Relator – Exhibit D

AWP Comparison

Drug Cost (per day of Tx)

This section calculates the base costs per day of treatment.

		Allegra (actual)	Claritin Pre-rebate (actual)	Claritin Post-rebate (actual)	Client Post-rebate (should be)	
A	AWP	$ 1.83	$ 2.14	$ 2.14	$ 2.14	Price Change Memo 4/2/98
B	Net Direct Price	$ 1.52	$ 1.78	$ 1.78	$ 1.78	Price Change Memo 4/2/98
C	Less Rebate (NDPLR)	$ 1.26	$ 1.60	$ 1.60	$ 1.60	17% Rebate for Allegra & 10% for Claritin

Additional Rebate A

This section computes the price adjustment needed to negate the differential between Claritin and Allegra

		Allegra (actual)	Pre-rebate (actual)	Post-rebate (actual)	Post-rebate (should be)	
D	Additional Rebate	$ -	$ -	$ 0.34	$ 0.34	Adjustment to equate Claritin's per day costs to Allegra's
E	Net Net Price	$ 1.26	$ 1.60	$ 1.26	$ 1.26	C-D

Physician Drug Risk Sharing

This section computes the amount that a physician would be required to pay the plan for over-utilization.

		Allegra (actual)	Pre-rebate (actual)	Post-rebate (actual)	Post-rebate (should be)	
F	AWP Target (PMPM)	$ 6.00	$ 6.00	$ 6.00	$ 6.00	For illustrative purposes only
G	Member Months	120	120	120	120	For illustrative purposes only
H	AWP Target Cost	$ 720	$ 720	$ 720	$ 720	F*G
I	AWP for Calculation	$ 1.83	$ 2.14	$ 2.14	$ 1.83	A
J	Days of Tx	395	395	395	395	H/I; # of days treatment needed to meet AWP Target
K	AWP Tx Cost	$ 720	$ 842	$ 842	$ 720	I*J
L	Penalty	$ -	$ 122	$ 122	$ -	Amount that a physician AWP costs are over the target
M	Risk Share	$ -	$ 61.20	$ 61.20	$ -	Amount that a physician would have to payback to plan

Total Plan Cost

The section calculates the total cost for the drug, including drug costs, rebates, and physician risk sharing.

		Allegra (actual)	Pre-rebate (actual)	Post-rebate (actual)	Post-rebate (should be)	
N	AWP	$ 720	$ 842	$ 842	$ 842	A*J; Total AWP cost for a given physician
O	Net Direct Price	$ 600	$ 702	$ 702	$ 702	B*J; Total NDP cost for a given physician
P	Less Rebate (NDPLR)	$ 498	$ 632	$ 632	$ 632	C*J; Total NDPLR cost for a given physician
Q	Additional Rebate	$ -	$ -	$ 134	$ 134	D*J; Total Additional rebate for a given physician
R	Net Net Price	$ 498	$ 632	$ 498	$ 498	E*J; Total drug cost for a given physician to a plan
S	Risk Share	$ -	$ (61)	$ (61)	$ -	M; Amount that a physician would have to pay the plan back
T	Total	$ 498	$ 571	$ 437	$ 498	R+S; The total cost to a plan for the drug, including the risk risk sharing arrangement

The goal of this program is for Claritin and Allegra to be equal grounds in terms of cost.

- Under the orginal arrangement (Pre-rebate), Claritin had a higher cost per day of treatment.
- With the inclusion of the added rebate (Post-rebate - Actual), Claritin had a lower cost per day of treatment than Allegra.
- In the Post-rebate - Should be model, Claritin's cost per day of treatment is the same as Allegra's.

TESTIMONY
OF
NICHOLAS J. MESSURI

ASSISTANT ATTORNEY GENERAL
DIRECTOR, MASSACHUSETTS, MEDICAID FRAUD CONTROL UNIT AND
PRESIDENT, NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

BEFORE

U.S. SENATE FINANCE COMMITTEE

216 Hart Senate Office Building
Washington, D.C.

JUNE 28, 2005

Mr. Chairman and Members of the Committee, Thank you for the opportunity to appear before you today to discuss the role of the states in investigating and prosecuting Medicaid fraud. I am Nick Messuri, Director of the Massachusetts Medicaid Fraud Control Unit. I am very pleased to speak to you today as the representative of the National Association of Medicaid Fraud Control Units, which I currently serve as President.

INTRODUCTION

The Medicare-Medicaid Anti-Fraud and Abuse Amendments, enacted by Congress in the 1970s, established the state Medicaid Fraud Control Unit Program and provided the states with incentive funding to investigate and prosecute Medicaid provider fraud, to prosecute the abuse and neglect of patients in all residential health care facilities which are Medicaid providers, and to investigate fraud in the administration of the Medicaid program. The Ticket to Work and Work Incentives Improvement Act of 1999 authorizes the Units, with the approval of the Inspector General of the relevant federal agency, to investigate fraud in other federally-funded health care programs if the case is primarily related to Medicaid. This law authorizes the Units, on an optional basis, to investigate and prosecute resident abuse or neglect in non-Medicaid board and care facilities, and emphasizes the necessity of having an integrated multi-disciplinary team of attorneys, investigators, and auditors working full-time on Medicaid fraud cases in order to successfully prosecute these complex financial crimes. The Units are required to be separate and distinct from the state Medicaid programs to avoid institutional conflicts of interest, and are usually located in the state Attorney General's office, although some Units are located in other state agencies with law enforcement responsibilities, such as the state police or the state Bureau of Investigation.

Because the federal government provides 75% of each Unit's costs, with the remaining 25% funded by the state, each Unit operates under the administrative oversight of the Inspector General of the U.S. Department of Health and Human Services and must be recertified annually. This funding formula allows the federal government to ensure that each Unit's activities are directed exclusively at provider fraud, fraud in the administration of the program, and resident abuse or neglect, and not at crimes lacking inappropriate Medicaid nexus.

State Medicaid Fraud Control Units are federally funded state-based law enforcement agencies entrusted with the responsibility of ridding the nation's Medicaid program of fraud and nursing home abuse. Since the inception of this national program in 1978, the forty-nine Medicaid Fraud Control Units have obtained thousands of convictions, recovered hundreds of millions of dollars in restitution, and perhaps even more important than any specific prosecution or recovery, demonstrably deterred the loss of many more hundreds of millions of dollars in Medicaid overpayments.

The need for the MFCUs became evident in the 1970s when the public and Congress realized that too many nursing home patients were held hostage by the greed of a small number of facility operators and other dishonest health care practitioners who saw fit to use the Medicaid program as their own private "money machine." To better understand how such a scandalous situation could have developed, one must first look at the structure of the Medicaid program. Medicaid was enacted by Congress in 1965 to provide a comprehensive range of medical services to people with disabilities and America's poorest citizens. It is sometimes confused with Medicare, the federal health insurance program for people sixty-five years of age and older and their eligible dependents. Unlike Medicare, however, which is federally funded and provides the same benefit coverage throughout the United States, Medicaid is financed by federal and state funds and is administered by each state. In addition to all fifty states, the District of Columbia and the territories participate in the Medicaid program.

Although Medicaid benefits might differ from state to state, a common problem that has plagued the program since the mid-1960s has been its skyrocketing costs. The reasons are many; pay and chase claims processing, increased enrollment, rising costs of medical care and prescription drugs, the frequency with which the services are used, and the lack of explanation of benefit forms sent to Medicaid recipients. Although most taxpayer dollars go directly toward providing needed medical care for the intended beneficiaries of the program, a tremendous amount of money is lost to fraud, waste and abuse.

The lack of comprehensive safeguards in the initial Medicaid legislation gave a small but greedy group of individuals free rein to steal millions of taxpayer dollars during Medicaid's first decade of operation. Functioning with few controls to prevent fraud, and without any specific state or federal law enforcement unit responsible for monitoring criminal activity, Medicaid faced expenditures that had already begun their upward spiral. If there was any question that fraud was hidden in this rapid cost increase, those doubts were put to rest when Congress conducted hearings and documented evidence of widespread misappropriation of taxpayer funds by a handful of unscrupulous health care providers.

While numerous Congressional hearings were bringing such abuses to light, it became clear that states such as New York, where a separate statewide investigative entity had been established, were able to increase substantially the rate of prosecutions and convictions and the recovery of taxpayer dollars.

As the law enforcement agencies primarily responsible for monitoring each state's Medicaid program, the MFCUs have uncovered some of the largest and most sophisticated frauds ever committed against the program. The MFCUs have seen wave after wave of fraud sweeping through nursing homes and hospitals, clinics and pharmacies, podiatrists and medical equipment vendors, radiology providers and labs, home health care providers and durable medical equipment vendors and, more recently, pharmaceutical companies. Each surge has brought its own special brand of profiteer in search of the next great loophole in the Medicaid program.

In addition to fulfilling their primary investigative and prosecutorial functions, the MFCUs work to identify and implement systemic reform initiatives in the administration of the Medicaid program. In an effort to maximize their effectiveness in detecting and preventing fraudulent practices within the Medicaid programs, the MFCUs have:

- Identified pharmaceutical products not subject to federal upper limit pricing, leading to the imposition of state upper limits on the pricing of many high-volume and high-cost prescription drugs;
- Developed and implemented changes in the approval process for Medicaid payments for durable medical equipment (including wheelchairs, specialty beds and therapeutic footwear) to ensure that expenditures for these goods are made only when they are medically necessary and accurately coded;
- Identified, investigated and remedied abusive patterns and practices in the submission of fraudulent expenses in the nursing home cost reporting system;
- Implemented computer edits and controls in the automated Medicaid payment process as a safeguard against improper disbursements;
- Redefined Program Integrity protocols;
- Identified computer software problems in Medicaid pharmacy billing programs;
- Provided training and technical assistance to improve fraud detection methods utilized by medical peer review organizations employed by the Medicaid program;
- Recommended and implemented changes in Medicaid provider enrollment screening processes to provide for effective background checks; and
- Identified improper billing for clinical laboratory testing that was not medically necessary.
- Developed a computerized tracking system to identify and prevent the rehiring of perpetrators of resident abuse;
- Worked with the HHS Office of Inspector General to develop protocols and procedures for a voluntary disclosure program to provide ongoing guidance to the health care industry and to encourage provider self-evaluation, prompt reporting of overpayments and voluntary disclosure of improper conduct;
- Drafted and successfully advocated for passage of legislation requiring background checks of home health aides and nursing home employees; and
- Assisted investigators from the Offices of the State Auditor and the United States Attorney in the investigation of mental health counseling corporations.

NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS (NAMFCU)

The National Association of Medicaid Fraud Control Units (NAMFCU) was established in 1978 to provide a forum for the nationwide sharing of information concerning the problems of Medicaid fraud control, to foster interstate cooperation on law enforcement and federal issues affecting the MFCUs, to improve the quality of Medicaid fraud investigations and prosecutions by conducting training programs and providing technical assistance to Association members, and to provide the public with information on the MFCU program. Of the 49 MFCUs that comprise the Association, 42 are located in the Office of the Attorney General and seven are located in other state agencies.

The Association gathers, coordinates and disseminates information to the various Units, maintains a library of resource materials and provides informal advice and assistance to its member Units and to those states considering the establishment of a Unit. NAMFCU conducts several training conferences each year and is called upon regularly to supply speakers for numerous health care fraud seminars. The *Medicaid Fraud Report*, the Association's newsletter, is published ten times a year and contains information concerning prosecutions by various states and reports of legal decisions affecting fraud control. Beginning with the first global settlement case in 1992, NAMFCU has worked effectively to coordinate multistate/federal investigations and settlements.

PROVIDER FRAUD SCHEMES

In the past decade, the MFCUs have seen a rapid increase in both the number of fraudulent schemes targeting Medicaid dollars and the degree of sophistication with which they are committed. Although the typical fraud schemes – billing for services never rendered, double-billing, misrepresenting the nature of services provided, providing unnecessary services, submitting false cost reports and paying illegal kickbacks – still regularly occur, new and often innovative methods of thievery continue to appear.

Perpetrators of Medicaid fraud run the gamut from the solo practitioner who submits claims for services never rendered to large institutions that exaggerate the level of care provided to their patients and then alter patient records in order to conceal the resulting lack of care. MFCUs have prosecuted psychiatrists who have demanded sexual favors from their patients in exchange for prescription drugs, nursing home owners who steal money from residents, and even funeral directors who bill the estates of Medicaid patients for funerals they did not perform.

SELECTED STATE MEDICAID FRAUD INVESTIGATIONS, PROSECUTIONS, AND SETTLEMENTS

The Units have identified serious fraud problems in numerous sectors of the health care industry, including hospitals, home health care agencies, medical transportation and durable medical equipment companies, pharmacies and medical clinics, and have prosecuted individual providers such as physicians, dentists and mental health professionals.

Examples of recent Medicaid Fraud cases follow:

HOSPITALS

- Two medical doctors who were faculty members at the University of Washington were convicted of felonies and the University hospital agreed to pay $35 million to settle the allegations. A *qui tam* complaint had been filed in federal court alleging that the University and its related physician billing groups billed Medicare and Medicaid for services performed by university residents and not the named physicians.

- In a *qui tam* case filed by two former employees of a Minnesota hospital, the employees alleged that the hospital home health services did not qualify for reimbursement. Negotiations between the U.S. Attorney's Office and the defendant resulted in a settlement of $500,000 for Medicare and Medicaid. The case was investigated by the U.S. Department of Health and Human Services, Office of Inspector General and the Minnesota MFCU.

PHYSICIANS

- A Texas physician was found guilty by a federal jury of Health Care Fraud, Mail Fraud, and Conspiracy. The defendant was sentenced to ten years in federal prison and ordered to pay $8.4 million in restitution. He operated a walk-in clinic, from which he billed Medicare, Medicaid, TriCare and the Federal Employee Health Benefits plans for treating as many as 200 patients a day. This case was worked jointly by the F.B.I., Defense Criminal Investigative Service (DCIS), the Office of Personnel Management (OPM), and the Texas MFCU.

- A Washington State physician pleaded guilty to one count of Health Care Fraud in U.S. District Court after submitting false claims for medical services to government sponsored health care benefit programs. The physician would see patients for a brief appointment or not at all, but then bill Medicaid for a comprehensive visit. She also routinely handed out prescriptions for highly addictive medications such as OxyContin without conducting any physical examination. She was sentenced to serve one year of incarceration, two years probation and ordered to make restitution in excess of $850,000 and to pay a $110,000 fine.

- The Oregon MFCU participated in a health care fraud investigation of a urologist who was accused of improperly billing Medicare and Medicaid for drugs received as free samples from the manufacturer. This case arose from information related to the settlement reached between the U.S. Department of Justice and the states with TAP Pharmaceutical Products, Inc. over TAP's marketing of the drug Lupron. The physician paid fines and penalties totaling $213,198.

- An Ohio physician billed for approximately 70 office visits per day while using a code indicating that the visits were substantial in length and involved complex diagnosis and treatment. The defendant pleaded to a bill of information of felony Medicaid fraud and paid $215,003 in restitution, $400,000 in forfeiture and was placed on probation for three years. He was also required to surrender his medical and DEA licenses. In addition to the Ohio MFCU, the investigating team included a number of state and federal agencies as well as private insurance companies.

- A physician in East Tennessee who submitted false claims, upcoded claims, misrepresented services, and billed for services not rendered was indicted by a federal grand jury on 95 counts of health care fraud and false statements. After a two week trial, the doctor was convicted on all counts, sentenced to 42 months in federal prison and three years supervised probation upon his release, and ordered to pay restitution of over $3,000,000.

- A Utah physician defrauded the Medicaid program by billing for IV therapy when in fact he was providing chelation therapy that is not covered by Medicare, Medicaid or private insurance. He has entered a plea of guilty to one count of the indictment and will pay restitution, surrender his medical and DEA licenses and be permanently excluded from the Medicare, Medicaid, TriCare and all other federal health care programs. This case was the result of a cooperative investigation and prosecution involving the HHS Office of Inspector General, the U.S. Attorney's Office and the Utah Medicaid Fraud Control Unit.

- The Vermont MFCU joined forces with the U.S. Attorney's Office and the HHS Office of Inspector General to investigate and prosecute an ophthalmic surgeon. The physician who was indicted by a federal grand jury on 80 criminal counts of healthcare fraud and falsifying medical records for allegedly performing unnecessary cataract surgeries over a period of 20 years on approximately 200 patients.

- A Kentucky anesthesiologist and his pain management corporation were indicted on allegations that the bilked the Medicare, Medicaid and other health benefits programs of $3.5 million. This was a joint investigation conducted by the Kentucky MFCU, the U.S. Attorney's Office, the Federal Bureau of Investigation and U.S. Department of Health and Human Services Office of the Inspector General.

PHARMACISTS

- A Kentucky pharmacist was indicted and convicted of multiple Medicaid fraud counts involving billing for high end cancer medications long after the recipients ceased using the drugs. He was sentenced to five years in prison and ordered to pay $40,000 in restitution.

- A Massachusetts pharmacist and his pharmacy corporation pleaded guilty to fraudulently submitting claims to Medicaid on behalf of ten patients for 89 prescriptions that were never ordered by physicians. The defendant was sentenced to 18 months and ordered to pay $85,746 in restitution.

- A New York pharmacist pleaded guilty to unlawfully selling more than 100,000 powerful painkillers and other drugs to addicts. To conceal his crime the defendant falsified the pharmacy's business records to make it appear that he was refilling the prescriptions according to their terms.

- A South Dakota pharmacist was employed at a hospital and also operated a private pharmacy. Throughout his employment at the hospital, he was able to purchase various drugs at an extremely reduced rate, then sold the drugs he purchased through the hospital at his own pharmacy. The pharmacist was able to realize a substantial profit because the state's Medicaid reimbursement is not based on actual price. The matter resulted in a federal conviction, including restitution in the amount of $82,798.

- A Pennsylvania pharmacist was charged with submitting pharmacy bills for high cost HIV medications that were not prescribed by physicians and/or never supplied to the patients. The indictment included 112 counts of Mail Fraud, Wire Fraud, Health Care Fraud and Tax Fraud. The case was jointly investigated by the Pennsylvania Medicaid Fraud Control Unit and the Pittsburgh Office of the F.B.I.

NURSING HOMES

- A nursing home management contractor who prepared cost reports each year for multiple owners of various nursing facilities in Mississippi pleaded guilty to Medicaid fraud for his preparation of a nursing home cost report. The contractor knowingly included the costs of personal goods and services of the facilities' owner and represented them as legitimate and allowable expenses of the nursing home. As a result of these misrepresentations, the owner was overpaid approximately $560,000 and used the funds to pay expenses for farm supplies, veterinary supplies, cell phones and improvements at his personal residence. The cost report also fraudulently claimed $447,280 in bogus management fees that were kicked back to the owner, and the owner has been charged with knowingly submitting a fraudulent cost report.

- The New York MFCU convicted a Pennsylvania nursing home and its owner of stealing millions of dollars over a ten year period by fraudulently billing for services not provided and for improperly obtaining payments from New York for services that Pennsylvania was already paying for. These services included basic dental treatment and occupational and speech therapy.

- A co-administrator of an Oklahoma nursing home pleaded guilty to charges of embezzlement and received a five year sentence. She was ordered to pay $37,000 restitution for stealing from patient trust funds and placing the money in her checking account for her personal use. She also pleaded guilty to Obtaining Money By False Pretenses by conspiring with two other employees of the nursing home to place the employees' relatives on the payroll and paying them for no-show jobs. The principal target was sentenced to a five year deferred sentence, while the two other employees pleaded guilty and paid restitution.

- A financial manager of two Colorado nursing homes embezzled approximately $97,000 from the personal needs account of nursing home residents. The manager was also convicted of several other schemes and sentenced to ten years in the Department of Corrections and ordered to pay restitution in the amount of $675,240.

DURABLE MEDICAL EQUIPMENT

- Two DME companies in Tennessee allegedly waived patient co-pays, gave kickbacks to doctors for certificates of medical necessity, billed for higher priced walkers than were supplied, and falsified prescriptions for specialty shoes for diabetic patients. The sales manager was indicted by a federal grand jury and pleaded guilty to one count of health care fraud for completing and causing to be completed sections of the medical necessity forms that should have been completed by the nursing staff.

- A Massachusetts durable medical equipment company paid $336,000 to the state Medicaid program for inflating the cost of its products.

- An Oklahoma provider of durable medical goods prepared false certificates of medical necessity for electric wheelchairs and then delivered power scooters to recipients instead of wheelchairs. Reimbursement for the wheelchairs was $5,000, compared to $1,500 for the scooters. The provider was sentenced to five months in federal prison, five months home detention, three years supervised probation, and ordered to pay $348,711 in restitution. This was a joint investigation conducted by the Oklahoma Medicaid Fraud Control Unit, the F.B.I. and HHS/OIG. The case was prosecuted by the U.S. Attorney's Office for the Northern District of Oklahoma.

- A Colorado provider of durable medical goods was prosecuted for obtaining the names and Medicaid patient numbers of elderly clients in the Denver area and billing Medicaid for thousands of dollars of durable medical equipment for each patient. The defendant was ordered to pay $45,350 in restitution.

LABORATORIES

- The California MFCU worked closely with a number of agencies on an investigation of a sophisticated scheme involving 29 defendants who:
    - stole the identities of several thousand beneficiaries and more than two dozen physicians;
    - bilked more than $20 million from California's Medicaid program (Medi-Cal) and approximately $1 million from Medicare; and
    - endangered the public's health and welfare through the creation of a black market for blood.

Between 1997 and 2000, this crime ring used more than 15 clinical labs in Los Angeles, Orange and Riverside Counties to illegally bill Medi-Cal and Medicare for tests that were not authorized by doctors and never performed. In order to evade detection, the defendants created the facade of a legitimate business operation by having testing equipment and blood specimens available on site, then billed Medi-Cal using stolen confidential information that was shared among the labs. To date, 23 of the 29 defendants have been convicted. The first ring leader was sentenced to 16 years in prison and ordered to pay $2.5 million in restitution, and $124,000 in back taxes to the state. The second ring leader was sentenced to 18 years and eight months in state prison and ordered to pay criminal penalties of $5 million, $2.5 in restitution to Medi-Cal and $903,000 in back taxes to the state.

MENTAL HEALTH PROVIDERS

- The executive director of a New Jersey mental health clinic was sentenced to three years in state prison for inflating patient billings to the Medicaid program and for submitting phony invoices for mental health counseling and psychological services that were never rendered.

- The co-owners of a Texas Licensed Professional Counselor group billed the Medicaid program for services that were not rendered and were indicted on charges of stealing approximately $646,000 in 2002 and 2003 from the Medicaid program by billing for services of counselors they no longer employed. Both of the defendants were found guilty of the same charges; one was sentenced to 35 years incarceration and the second received a record prison sentence of 63 years confinement.

- An Arkansas mental health provider reached a settlement agreement with the MFCU to repay the Arkansas Medicaid Program Trust Fund $120,000 for services that could not be verified by documentation.

- The Illinois Medicaid Fraud Control Unit obtained a guilty verdict against a mental heath provider for improperly billing Medicaid in excess of $400,000 for psychiatric services. The investigation revealed that the defendant billed for services that were never provided or were provided by unlicensed counselors.

- After a week-long trial, a Minnesota jury found an unlicensed psychologist guilty on two counts; theft by swindle over $35,000 and misrepresentation of her credentials as a licensed psychologist. She was sentenced to 27 months of incarceration and placed on probation for 20 years.

MEDICAL CLINICS

- A physician and the co-owners and managers of a now defunct infectious disease clinic in Miami were arrested on racketeering charges after they improperly billed the Florida Medicaid program for over $1.1 million. The scheme involved the use of the physician's provider number with his knowledge when he was not present at the clinic and therefore could not have provided the treatment in question. In addition, they billed Medicaid more than$4.7 million for pharmaceuticals that were never administered to patients at the clinic. The investigation also resulted in arrests and convictions of the clinic's president and director of nursing.

- Two Ohio medical clinics required patients to be seen every two weeks as a condition of receiving prescriptions. Office visits usually lasted for approximately two to three minutes but were billed as 45-60 minute visits. Additionally, the patients were required to have physical therapy, and would be refused their prescriptions if they did not cooperate. A task force of MFCU and HHS OIG agents conducted a joint investigation, and the owner and the corporation were convicted of three felonies and ordered to pay $3,500,000 in restitution and to sell the clinics.

- The prosecution of a Louisiana registered nurse and her husband, former owners of a now-defunct clinic, resulted in convictions on nine felony counts of Medicaid fraud, felony theft and money laundering of $100,000 or more. The MFCU investigation revealed that the clinic fraudulently billed the Louisiana Medicaid Program more than $400,000 for fictitious services for indigent children, including well-care nursing and nutritional consultations.

DENTISTS

- A dentist in the District of Columbia pleaded guilty to one count of health care fraud. The defendant was a participating provider in a number of dental care programs, and although she was paid a fixed fee for providing routine services to patients, she was entitled to supplemental reimbursement for providing more invasive procedures. In her guilty plea, the defendant admitted billing for these invasive procedures for at least 60 Medicaid recipients when she had not performed the work. As part of her plea, the defendant paid $15,374 to the Medicaid program, was sentenced to two years of probation, and was ordered to undergo evaluation and treatment for drug abuse. The MFCU has requested that the defendant be excluded from participation in all federal health care programs.

- A New York dentist admitted to stealing more than $50,000 from Medicaid by fraudulently billing Medicaid for dental services not performed. The defendant was sentenced to five years probation and ordered to pay $175,000 in restitution.

- A South Carolina dentist was convicted of two counts of Filing False Claims with the South Carolina Medicaid program for services that had not been provided and was sentenced to a three year suspended sentence and a $1,000 fine.

HOME HEALTH

- A Pennsylvania provider of home health services forged time sheets and inflated hours as a basis for submission of claims to the Medicaid program. The defendant was convicted of Medicaid Fraud, Perjury, Theft by Deception, Forgery, Tampering with Public Records and Criminal Conspiracy. The provider's husband was also sentenced to two to four years in the state Correctional Institution for his role in the scheme.

- An owner of a home health care franchise pleaded guilty to felony theft from the Maryland Medicaid program and was sentenced to eight years incarceration, with 27 months to be served. He was ordered to pay $250,000 in restitution to Medicaid, and an additional $750,000 in penalties. The defendant had operated a home health care franchise in Maryland and inflated the cost reports he submitted by including expenses incurred by an unrelated business.

OTHER PROVIDERS

- The Massachusetts MFCU recovered $50,000 from an optometrist who submitted improper claims for services for elderly nursing home residents.

- In a joint investigation by the federal government and the Virginia MFCU, the owner/operators of an intensive in-home mental health services provider were convicted of fraudulently billing the Virginia Medicaid program for approximately $2.5 million. They had billed for services that were not provided, upcoded and billed at higher reimbursement levels, and billed for services that were not covered as part of Medicaid's reimbursement policies. One of the defendants was sentenced to six months incarceration and six months of electronic monitoring, and the second was sentenced to 46 months incarceration. They were jointly ordered to pay the Virginia Medicaid program $2.5 million, the largest case for the Virginia MFCU to date.

- The Rhode Island MFCU's recent Medicaid Fraud settlements have resulted in the return of approximately one million dollars to the Medicaid Program. One such case involved Coram, a home-based therapeutic company that submitted false invoices on behalf of two recipients from April 1995 through April 2002. Coram paid $195,000 to the Department of Human Services and $5,000 to the MFCU for investigative costs.

- Maine settled charges of illegal drug switching by Omnicare of Maine, a pharmacy that serves clients in long-term care facilities statewide. The Complaint alleged that Omnicare of Maine violated the False Claims Act, the Unfair Trade Practices Act, and the Maine Pharmacy Act by switching patients from the prescribed Ranitidine tablets to unprescribed Ranitidine capsules. Omnicare paid $1,080,000 in fines, damages and costs to settle the case.

- The Vermont MFCU brought a three-count indictment against a defendant who fraudulently obtained control of nearly half a million dollars in Medicaid funds and embezzled approximately $139,000 from a non-profit agency that provided Medicaid waiver services to severely disabled children. The defendant was convicted of one count of Medicaid fraud, paid restitution in the amount of $89,105 and received a sentence of five to ten years.

- A Missouri speech therapist pleaded guilty to three counts of Health Care Payment Fraud and Abuse. He was sentenced to four years imprisonment, sentence suspended, and the court ordered restitution to the Missouri Medicaid program in the amount of $105,210.

- The owner and operator of a Delaware transportation company engaged in widespread overcharging of the Delaware Medicaid program for medical transportation. After a jury trial, the prosecution resulted in a conviction on five counts of Felony Health Care Fraud.

- A New Hampshire podiatry practice was convicted of Medicaid fraud after filing more than 80 fraudulent Medicaid claims to obtain reimbursement for orthotic foot devices and was ordered to pay restitution in the amount of $18,330. A parallel civil settlement with the company president resulted in the payment of $40,000 in civil penalties to the Medicaid program and the company's termination as a Medicaid provider.

- The South Dakota MFCU brought an action against non-licensed individuals who performed physical therapy on patients and then billed Medicaid, Medicare and private insurers for the services. Restitution to Medicaid was determined in the amount of $15,786 and an additional $15,018 was assessed as a civil penalty.

- The part owner and controller of an Intermediate Care Facility for individuals with mental retardation (ICF-MR) headquartered in North Carolina pleaded guilty to one count of Attempt to Obstruct a Criminal Investigation of a Health Care Offense (a federal crime) and was sentenced to three years probation, ordered to pay a $20,000 fine and to serve 100 hours of community service. He also entered into a civil settlement with the federal government and the state of North Carolina under which the company agreed to pay $102,972. The defendant part owner leased equipment from a contract services company and paid exorbitant rates for leasing equipment from the company without appropriate disclosures. He also attempted to obstruct the investigation by telling the straw owner to lie to investigators regarding specific business transactions between the two entities. As a result of the investigation, the assets of the contracting company were seized and forfeited, at a value of $727,251.37.

MFCU GLOBAL INVESTIGATIONS AND SETTLEMENTS

Interaction With Federal Agencies: One important feature of the MFCU oversight program is the effort to forge close and effective working relationships with state and federal agencies to combat fraud and abuse in the Medicaid programs of the various states. These cooperative efforts have grown out of the relationship between MFCUs and HHS-OIG, which has oversight over the MFCU program. Medicaid fraud is a crime under both state and federal statutes, may be prosecuted in either state or federal courts. Consequently, all MFCUs work closely with the Offices of the United States Attorneys in their respective states and with federal law enforcement agencies such as the U.S. Department of Justice, the FBI, HHS/OIG, the Internal Revenue Service and the U.S. Postal Service. There are active state-federal health care fraud task forces and working groups in virtually every state in the country, and the MFCUs regularly participate in these task forces and working groups.

Cooperative efforts between state and federal authorities have proven very effective in protecting the Medicaid and Medicare programs from health care providers or vendors who defraud both programs and whose misconduct occurs in multiple states. Multi-state cases in which the MFCUs played a role have resulted in the return of almost a billion dollars to the Medicaid program. Defense attorneys recognize that settling an investigation brought by one state Medicaid program does not resolve Medicaid claims in other states, and that most states, like the federal government, have the authority to exclude a convicted provider from their health care programs. Accordingly, resolution of these cases would be difficult or impossible if the targets were required to negotiate separate terms and obtain separate settlement agreements from each state.

The federal False Claims Act (FCA) includes *qui tam* provisions which provide the authority and financial incentive to private individuals or "relators" to enforce the Act on behalf of the government. *Qui tam* relators, often called "whistleblowers," are generally current or former employees of target entities and are protected by the Act from retaliatory actions by their employers. A *qui tam* complaint is filed under seal in federal district court and remains under seal for at least 60 days (and often much longer) to allow the government to conduct a thorough investigation. In addition, fifteen states currently have false claims statutes with *qui tam* provisions, and an increasing number of relators are filing their cases with the states as well as the federal government. This development has fostered a significant increase in state/federal investigative partnerships.

The state Medicaid Fraud Control Units are generally notified about an ongoing investigation or case when the United States Department of Justice (DOJ) or a United States Attorney's Office (USAO), relator's counsel, defense attorney, or other source, contacts the National Association of Medicaid Fraud Control Units (NAMFCU) and requests the assistance of the MFCUs. NAMFCU obtains relevant information, such as the name of the parties, the subject of the conduct under investigation, and the type of criminal or civil violations suspected, then prepares a list of states affected by the suspected wrongdoing. The NAMFCU President then determines if it is appropriate for the states to participate and whether an investigative team should be appointed.

If the investigation reaches the settlement stage, the NAMFCU team will contact the defendant to set out basic ground rules, including the framework for negotiations (exclusion/ non-exclusion, criminal pleas and/or civil settlement, the payment of the team's expenses attributable to the negotiations, etc.). In joint federal-state cases, this process takes place in cooperation with federal attorneys assigned to the matter.

There are other crucial factors to consider in a settlement, such as the provider's ongoing economic viability, the effect on shareholders, potential employment impact on specific communities, and the effect that exclusion from Medicaid, Medicare and other state and federal health care payment programs will have upon the Medicaid beneficiaries' access to adequate and convenient medical care. Settlements may include additional issues such as incarceration of individual employees or officers, corporate reorganization and compliance or corporate integrity agreements ("CIAs"). The negotiations are highly confidential and often are governed by grand jury secrecy requirements, *qui tam* provisions, privilege issues and SEC statutes and regulations.

Under NAMFCU protocols, all state recoveries are allocated based upon a state's actual damages. The participating states usually are asked to supply state specific data regarding the defendant's billings, although it is sometimes possible to calculate state losses from information supplied by the federal government or through discovery from the defendant. The NAMFCU settlement team, in conjunction its partners in the federal government, is committed to negotiating for the best settlement possible for its member states, and will in appropriate circumstances seek penalties as well as damages.

Examples of recent federal/state global settlements follow:

ABBOTT LABORATORIES

Abbott Laboratories, a manufacturer of pharmaceutical and medical products, settled a $414 million case with the government for defrauding state Medicaid and federal Medicare programs through the marketing of its enteral feeding pumps and related supplies.

As part of the settlement agreement entered in federal court for the Southern District of Illinois, Abbott paid $364,816,174 in damages and penalties to the Medicare program and $49,638,575 to the Medicaid programs of the 50 states and the District of Columbia. C.G. Nutritionals, an Abbott subsidiary, also pleaded guilty to a federal charge of Obstruction of a Criminal Investigation of Health Care Offenses and paid a criminal fine of $200 million to the federal government.

The investigation showed that Abbott's Ross Products Division:

- Provided free enteral feeding pumps to nursing homes and DME suppliers in exchange for an agreement tat those buyers would purchase a specific number of pump sets;

- Told nursing homes and DME suppliers they could bill Medicare or Medicaid for pumps that had been supplied free of charge; and

- Paid improper financial incentives to DME suppliers and nursing homes to buy products from Ross.

ASTRAZENECA PHARMACEUTICALS LP

AstraZeneca Pharmaceuticals LP (Zeneca) agreed to pay $24 million to the state Medicaid programs for damages caused by Zeneca's marketing practices for its drug Zoladex, used for the treatment of prostate cancer. This agreement settled claims on behalf of all 50 states and the District of Columbia. The multi-state settlement was reached in conjunction with a federal settlement negotiated by the United States Attorney's Office in Delaware. Under the federal agreement, Zeneca pleaded guilty to a charge of conspiracy to violate the Prescription Drug Marketing Act and entered a civil settlement to pay damages to Medicare and other federally funded health care programs.

Zeneca was accused of providing quantities of Zoladex to physicians and other providers free of charge, knowing and expecting that those free samples would be billed to the Medicaid and Medicare Programs, and of improperly giving physicians educational grants, consulting services, entertainment expenses and honoraria in exchange for orders of Zoladex. Most significantly for the states, Zeneca failed to include the free Zoladex in the calculation of its "best price" as required under the federal Medicaid drug rebate program, causing the state Medicaid programs to receive lower rebate amounts than were due.

As part of the agreement with the states, Zeneca will be required to report accurate pricing information to the state Medicaid programs for Zoladex and for other drug products marketed to physicians and clinics for in-office administration. Additionally, Zeneca will cooperate with the states in investigating individuals, including physicians, who have caused overcharges to the Medicaid programs by taking advantage of Zeneca's marketing schemes.

RITE AID

Thirty state Medicaid Programs recovered over $6.6 million dollars as a result of a settlement with Rite Aid Corporation. Rite Aid, a national retail pharmacy chain, agreed to pay a total of $7 million to the federal and state governments to settle allegations that the company dispensed partial or "short" prescriptions due to insufficient stock and returned unfilled medications to stock, but still received full payment from government health insurance programs (Medicaid, Tricare and the Federal Employee Health Benefit program).

The Rite Aide settlement includes a Corporate Integrity Agreement (CIA) that will be administered by the HHS/OIG. The CIA requires the company to modify its pharmacy billing operations to ensure future compliance with applicable laws and Medicare and Medicaid regulations.

SCHERING PLOUGH, INC.

Forty-nine states and the District of Columbia reached an agreement with pharmaceutical manufacturer Schering Plough, which paid $140.7 million to the state Medicaid Programs for damages and penalties from Schering's underpayment of Medicaid Drug Rebates on its blockbuster antihistamine drug, Claritin.

The federal Medicaid Drug Rebate statute requires all pharmaceutical manufacturers that supply products to Medicaid recipients to provide the Medicaid Programs the benefit of the "best price" available for their product. The manufacturers are obligated to file "best price" information with the Centers for Medicare and Medicaid Services ("CMS"); CMS then uses this information to calculate rebates for the state Medicaid Programs. The reported "best prices" reported by manufacturers must include discounts, rebates, payments and other incentives, but Schering failed to notify the government of substantial concessions and incentives offered to certain HMO purchasers of Claritin. The result was that the states received millions less in rebates from Schering than would have been paid had "best price" been reported appropriately. Schering paid a total of $282.3 million to resolve its civil liability for this conduct.

PARKE-DAVIS/ WARNER-LAMBERT

The 2004 global federal and state settlement in this matter arose from a 1996 False Claims Act whistleblower case brought by David Franklin, a former medical liaison for Warner-Lambert. Franklin's lawsuit alleged that Warner-Lambert's Parke-Davis Division engaged in a scheme to promote the use of Neurontin for a wide variety of unapproved uses, including the treatment of psychiatric conditions, migraine headaches and attention deficit disorder. At the time, Neurontin had FDA approval only as an adjunct therapy for epilepsy. Federal law prohibits pharmaceutical companies from promoting their products for uses that have not received specific approval from the FDA. The total amount of the settlement to the state Medicaid programs nationwide (restitution and penalties) was $152 million.

The settlement was negotiated by the U.S. Attorney's Office in Boston, the National Association of Medicaid Fraud Control Units and a task force of representatives of the consumer protection divisions of the offices of the state Attorneys General. The resolution of the case required the manufacturer to pay restitution and penalties to the state Medicaid programs and to fund remedial programs designed to benefit consumers. In addition, Warner-Lambert, now a subsidiary of Pfizer, Inc., pleaded guilty by to a criminal violation of the Food, Drug and Cosmetic Act and paid a substantial criminal fine. Pfizer also agreed to the terms of a Corporate Integrity Agreement, under which its marketing practices will be subject to federal scrutiny for a period of three years.

SELECTED SIGNIFICANT RESIDENT ABUSE AND NEGLECT ENFORCEMENT EFFORTS BY THE STATE MEDICAID FRAUD CONTROL UNITS

Many MFCUs use their criminal and civil enforcement authority to investigate and prosecute the insidious and often hidden abuse of nursing home residents, including both financial exploitation and physical abuse of vulnerable and fragile senior citizens. Some of these cases involve allegations of sexual abuse, corporate neglect, drug diversion, misappropriation of patient trust funds, and have included prosecutions of caregivers for homicide and manslaughter. In addition, Units across the country have launched innovative training and public outreach programs to educate health care professionals and the public about the prevalence of elder abuse. Other important activities undertaken by the Units include legislative efforts to enhance and reform the laws that protect residents from these abuses and the referral of state criminal convictions, judgments and licensing actions to the HHS Office of the Inspector General so that individuals who are convicted of these crimes may be excluded from working in any facility or program that receives Medicaid funding. Examples of these initiatives follow:

PHYSICAL ABUSE

It is difficult to conceive of a more vulnerable, less threatening group than residents of long-term care facilities, but too often they are the target of cruel and sometimes sadistic violence and mistreatment. Tragically, the perpetrators of physical abuse are usually those charged with the care and well-being of patients in long-term care facilities.

- A licensed practical nurse was arrested in Pennsylvania, and charged with one count of Neglect of a Care-Dependent Person, and four counts of Simple Assault. The LPN was observed striking patients to make them comply with her orders.

- A patient aide at an Intermediate Care Facility for individuals with mental retardation (ICF-MR) in Kentucky abused a 37-year-old male resident by striking him in the stomach with his fists. Upon his plea of guilty to the one misdemeanor count of abusing an adult, the defendant was sentenced to 12 months in the county jail. The defendant is also prohibited from ever seeking employment at any facility that cares for the physically or mentally infirm.

- A nursing home employee was charged with and convicted of patient abuse in a Montana facility after an investigation into the allegation that she had struck a resident with his own arms and stuck his urine soaked t-shirt in his mouth. She was fined, given a suspended jail sentence and excluded from the Medicaid program.

- The Vermont MFCU obtained the conviction of a nurse's aide after the aide struck an 81-year-old male resident of the nursing home, leaving a fist-shaped mark on the man's sternum. The defendant received a deferred sentence and was placed on probation for two years. As part of his probation, he is prohibited from being employed to give direct care to elderly and disabled adults. The resolution of the criminal case also triggered an administrative action by the federal Center for Medicare and Medicaid Services which will exclude him from employment in any Medicare or Medicaid funded position for a minimum of five years.

- A certified nursing assistant (CNA) in Washington State pleaded guilty to one count of Fourth Degree Assault. after she slapped a wheelchair bound 91-year-old suffering from dementia, neuropathy and leukemia. She was sentenced to 365 days in jail, with all but one day suspended, and a $5,000 fine suspended on condition of having no criminal law violations and attending anger management classes. The Washington State Department of Health revoked her certification to practice as a nursing assistant with no right to re-apply for at least five years.

- A nurse was convicted of one count of patient abuse at a Delaware long-term care facility after holding his hand over an elderly victim's mouth to quiet the victim.

- The Massachusetts MFCU obtained a 4 to 5 year committed state prison sentence against a CNA after a three week jury trial, proving that she abused five elderly Alzheimer patients including force-feeding one patient her own feces and slapping, kicking and spitting on other patients who lived at the nursing facility. The key to the success of the prosecution was convincing co-workers to come forward and testify after they had been intimidated by the defendant.

- Two nurse's aides in North Carolina pleaded guilty to simple assault after an investigation revealed that they dragged a nursing home resident through the halls of the facility because she resisted taking a scheduled bath. The resident suffered floor and carpet burns to her back as a result of the incident.

SEXUAL ABUSE

Sexual abuse of frail elders and people with disabilities is seldom discussed but occurs all too frequently. These individuals are easy prey for sexual predators because many of them sleep in unlocked rooms and regularly submit to physical contact in order to receive care.

- A nursing assistant in Minnesota was charged with four counts of criminal sexual conduct after he assaulted a nursing home resident, and was found guilty on two counts. He was sentenced to 33 months of incarceration and five years of supervised probation, and he must register as a sex offender and provide a DNA sample to the state.

- A New Hampshire neurologist at the state's psychiatric hospital pleaded guilty to charges involving the sexual assault of a patient. The MFCU successfully argued an issue of first impression under the governing sexual assault statute, which precluded health care providers from claiming the patient's alleged consent as a defense. Two of the assaults occurred while the defendant was treating the patient at the hospital. The defendant was sentenced to one year of incarceration, six months suspended, with a consecutive suspended state prison sentence, and was barred from seeking reinstatement of his medical license for four years.

- A residential treatment worker was convicted of the offenses of Sexual Abuse in the Third Degree and Wanton Neglect of a resident of a health care facility in Iowa and was sentenced to 12 years of imprisonment and fined. The female victim was unable to provide testimony because she suffered from profound mental retardation and lacked communication skills. The cornerstone of the prosecution was DNA-analysis evidence that was garnered from clothing of the defendant secured after the issuance of a search warrant at his residence. This conviction has since been reviewed and affirmed by the Iowa Court of Appeals and the Iowa Supreme Court.

- A male registered nurse at a Tennessee mental health institute was suspected of engaging in sexual intercourse and other sexual acts with a female patient under his care. After an extensive investigation that raised many difficult issues, including the credibility of the victim and the fact that no other witnesses could be located, the R.N. was indicted. He was later convicted after a jury trial and sentenced to 30 days incarceration and two years supervised probation, sex offender treatment counseling, placement on the sex offender registry, 20 days public service, and loss of his nursing license.

PATIENT TRUST FUNDS

Federal regulations provide that the MFCUs may review complaints of the misappropriation of patients' private funds in nursing homes, and many of the Units investigate and prosecute these financial crimes.

- In Oklahoma, the administrator of the Grace Living Center was given a ten year suspended sentence and ordered to pay $32,590 in restitution for diverting the residents' funds for his own personal use.

- The office manager of a New Hampshire nursing home pleaded guilty to theft after stealing funds from more than 12 patient accounts. The defendant was sentenced to six months in jail, suspended, and was ordered to make restitution of more than $10,000.

- An owner/administrator of a residential care center in South Carolina transferred $61,508.16 of residents' funds into an operating account and used the funds for her own benefit. She was convicted and sentenced to a three year sentence and ordered to pay restitution.

- The financial manager of two nursing homes in Colorado was sentenced to ten years in the Department of Corrections and ordered to pay $672,240 in restitution. She had embezzled approximately $97,000 from one home and collected payments from the families of nursing home residents at the other.

- A business office assistant employed at two nursing homes in Richmond, Virginia embezzled funds from the patient trust accounts at both homes and was found guilty of two counts of embezzlement and one count of forgery. She was sentenced to a total of 30 years in prison with 25 years suspended and ordered to pay $15,279 in restitution.

- In the largest patient trust fund case in the history of the Texas MFCU, the former business manager of a Texas nursing facility pleaded guilty to diverting resident and facility funds. He issued 452 "petty cash" checks from the resident trust fund, totaling $368,367 for his own benefit. He was sentenced to ten years probation and ordered to serve 90 days in jail in addition to being ordered to make full restitution.

PATIENT NEGLECT

Those who accept the position of trust as caregivers to dependent, vulnerable adults should be held accountable for neglecting those in their charge. Failure to provide care and treatment to residents of nursing homes and board and care homes can be every bit as dangerous and harmful as intentional assaultive behavior. Many states have brought prosecutions against caregivers and sometimes against facility owners in cases where they have failed to provide adequate care and treatment to residents.

- The Kentucky MFCU led a three year joint agency investigation of a nursing home's practices and a catastrophic failure of care. The management corporation pleaded guilty in state court to criminal Medicaid Fraud and paid a total of $1.2 million dollars in fines and restitution to the Medicaid program. The owners also entered into an agreement with the federal and state government, and paid a total of $432,815 in civil monetary penalties and false claim liabilities.

- The Nebraska MFCU is planning to file both criminal and civil actions involving a case where a severely handicapped woman was allowed to develop third and fourth degree pressure ulcers while residing at a group home facility. The evidence shows that her medical needs far exceeded the licensure level of the facility and the management knew it. The Unit will be seeking to recover all Medicaid funds paid for this patient's care before and after the injuries, an amount in excess of $200,000.

- Four owners of a medical center in Florida were arrested and charged with patient neglect, after patients were denied needed medications, did not receive proper nutrition, failed to have access to staff and endured poor sanitary conditions. One resident with a history of severe mental illness was found to have left the facility and wandered into a busy intersection outside of the facility. The facility had received over $3.5 million dollars in Medicaid funds during its last year of operation, yet failed to pay its own employees for months at a time.

- The New York MFCU has created a Nursing Home Initiative, which examines corporate, institutional and executive liability for conditions leading to poor patient care and resident abuse. The Initiative has achieved several criminal convictions based upon unprecedented applications of New York's penal and public health laws. For example, two nursing homes agreed to repay $3 million to the Medicaid program after the MFCU concluded (1) that the nursing homes operated without sufficient skilled nursing staff to deliver basic care to all of its residents; (2) that some residents did not receive the care that they were entitled to; and (3) that some of the homes' employees falsified records to show the delivery of care that had not been provided. In another case, a New York nursing home was held criminally liable for failing to provide adequate staff to care for residents. The nursing home corporation also admitted that its employees falsified business records to conceal that licensed practical nurses were unlawfully performing medical assessments. As a result, the corporation and its two owners agreed to divest themselves of their nursing home operations and were permanently enjoined from having any further involvement in the management, operation or ownership of any nursing home in New York State. In addition, the corporation was ordered to pay $1 million in restitution to the Medicaid program and $17,000 in fines.

- The Arkansas MFCU reached a settlement agreement with Beverly Enterprises, Inc., resulting from 42 separate investigations of resident mistreatment or neglect in several Beverly facilities in Arkansas. As a result of the investigations, Beverly agreed to pay the Arkansas Medicaid Program Trust Fund $1.3 million. In addition, Beverly agreed to pay $200,000 to the University of Arkansas Medical Sciences Center on Aging for research to improve the quality of care for nursing home residents in Arkansas.

- A nursing home in Illinois was closed by federal and state regulators because of deficient patient care, including unsafe, dangerous, hazardous and unsanitary nursing facility conditions. In addition, the nursing home paid $594,500 because the Illinois Medicaid program had reimbursed the home for services that were not provided.

- A Massachusetts nursing home owner paid $660,000 to Medicaid for failing to provide adequate nursing staff levels to meet the basic health and safety needs of residents. The MFCU used medical experts to determine that nursing staff levels were too low resulting in high rates of medication errors, inadequate supervision to prevent accidents, substandard nutrition levels and high incidence of skin sores in hundreds of patients.

INVOLUNTARY MANSLAUGHTER/ HOMICIDE

On occasion, the MFCUs prosecute caregivers at nursing homes and group homes for negligent homicide, involuntary manslaughter and homicide.

- The Louisiana MFCU brought charges against a nurse and a nursing assistant at a nursing home for negligent homicide. The nurse was responsible for the care of a resident who was found dead from suffocation after her tracheotomy tube was dislodged.

- The Maryland MFCU convicted a caregiver at a group home for the developmentally disabled of two counts of involuntary manslaughter and one count of reckless endangerment. He was sentenced to five years of incarceration with 15 months to be served. The defendant failed to monitor electric stove burners, and two residents died of smoke inhalation when the facility caught fire.

- The Arkansas Unit investigated a homicide at a nursing home after two certified nursing assistants (CNAs) beat a resident to death with a set of brass knuckles. One CNA pleaded guilty and was sentenced to 30 years in prison and the other is awaiting trial on Capital Felony Murder charges.

FAILURE TO REPORT

Reporting requirements play an important role in protecting residents from abuse and/or neglect and most states statutes dealing with patient abuse include a mandatory reporting section. The statutes differ, however, as to who is considered a mandated reporter and which agency receives the report. The enforcement of these reporting requirements is vital because many victims are unable to speak coherently, and witnesses may fear retaliation from the abuser, their associates, or the facility itself.

- An employee of a Missouri nursing home assaulted a facility resident by striking him in the head, and the resident died as a result of the injuries. The employee later pleaded guilty to elder abuse in the first degree and was sentenced to 15 years in the Missouri Department of Corrections. The president of the management company and the facility administrator knowingly failed to immediately report this incident of abuse as required. A jury found the president, the company (through the president), and the nursing home guilty of failure to report elder abuse. The court sentenced the president to one year imprisonment in the county jail and payment of a fine of $1,000, and sentenced the management company and the nursing home administrator to pay a fine of $5,000 each.

- An administrator of a skilled nursing facility in California failed to report an incident of suspected dependent adult abuse and was sentenced to six months in jail, placed on three years of probation and ordered to complete 500 hours of community service. Following an appeal to the California Court of Appeals, Fourth District, the three-judge panel unanimously issued a ruling that will have an impact on all future failure-to-report cases. The court ruled that: (a) a purely objective standard applies to a "reasonable suspicion," which triggers a duty to report elder and dependent adult abuse; (b) a violation of the state's mandated reporting law is a strict liability offense, and does not require a finding of criminal negligence; and (c) a nursing home administrator has a duty to report abuse upon receipt of a victim's direct or indirect report of abuse, and once elder and dependent abuse is suspected, the designated outside agency, not the mandated reporter, has the responsibility to investigate and determine whether abuse actually occurred.

CRIMINAL BACKGROUND CHECKS

An important step in preventing resident abuse in nursing homes is to stop individuals with a criminal background from working in the facility. While many states require a nursing home to check an applicant's record prior to hiring, in too many instances this requirement is not enforced. Many individuals employed as caregivers in nursing homes have been convicted of a crime or even a series of crimes.

- A nursing assistant in Washington State pleaded guilty to one count of Forgery and was sentenced to 12 months probation, and was ordered to pay $500 to the Crime Victim's Compensation Fund, $200 in attorney fees and $110 in court costs. The defendant had applied for employment as a nursing assistant at a long-term care facility in Washington State and completed a Criminal Conviction Background Check as part of the application process. Her application falsely stated that she was employable in all medical facilities, and that her prior criminal conviction had been for a non-reportable juvenile offense.

DRUG DIVERSION IN NURSING HOMES

One of the most common types of neglect occurs when the professional caregiver fails to follow a plan of care or fails to provide medication pursuant to a physician's orders.

- An employee of a nursing facility in Iowa pleaded guilty to three counts of Obtaining a Prescription Drug by Fraud. She admitted to taking three Duragestic Patches, a Schedule II narcotic, from residents in her care and was sentenced to be imprisoned for a period of up to ten years for the three counts and ordered to pay restitution.

- The Vermont Unit obtained multiple convictions in a jury trial involving a registered nurse who diverted morphine from a terminally ill nursing home resident's CADD pump, and also used a syringe to remove the narcotic fentanyl from the patches administered placed on nursing home residents. The nurse was caught on a surveillance camera placed in the facility by Unit investigators. In addition to charges of abuse, the jury found the nurse guilty of illegally possessing and consuming the narcotics, and she was sentenced to three years imprisonment on a four to ten year sentence on drug and elder abuse charges. In addition to jail time, the sentence provides for a variety of special conditions of probation after she completes her term of incarceration, restricting her employment and access to regulated narcotics and alcohol and requiring her to continue treatment and to submit to monitoring by her probation officer. In accord with the plea agreement, she was required to reimburse Vermont's Medicaid program $1,000 for the value of the drugs she diverted and to make a $5,000 donation in lieu of fines to the Victim's Compensation Fund. She also agreed to be interviewed by staff of the Vermont Attorney General's Office for an educational videotape on drug addiction for health care workers.

- A registered nurse in Oregon was convicted of criminal mistreatment in the First Degree. Oregon MFCU investigators received information that she had been fired from a long-term care facility for "documentation errors" in the patient records. Narcotic records at the facility indicated that she was checking out large quantities of Vicodin without making corresponding entries in the patient records that the medication was actually administered. Further investigation revealed a pattern by the nurse of taking the maximum doses of Vicodin from six patients on a daily basis when the drug had been prescribed on a PRN (as needed) basis. During a six month period, the nurse (whose duties did not include administering medications) received 1,931 pills to be dispensed to residents, while only 23 pills had actually been administered to patients. Under Oregon's Criminal Mistreatment law, a caretaker can be charged with a felony if she steals – regardless of amount – from an elder or dependent person in her care. The case was prosecuted without the testimony of any of the victims, who were not in a condition that would allow them to testify.

- A Director of Nursing was investigated by the Indiana Medicaid Fraud Control Unit for diverting residents' controlled substances and for falsely obtaining other drugs through her position at the long term care facility. She pleaded to four counts of Medicaid fraud and four counts of forgery and was sentenced to four years suspended, four years probation, 18 months home detention and restitution.

- A registered nurse employed at a nursing home in Maine drained the liquid morphine prescribed for an 85-year-old woman suffering from coronary problems and replaced it with saline and tampered with the patient's morphine pills. This case was prosecuted in federal court and the nurse was sentenced to 71 months in federal prison and three years probation.

LEGISLATION

The Medicaid Fraud Control Units, based upon their unique and lengthy experience in investigating and prosecuting resident abuse and neglect, have long urged the strengthening of state and federal resident abuse laws and regulations. Statutes and regulations have been in place to protect children and the mentally disabled, and the MFCUs believe these same protections should be afforded the sick and elderly who reside in nursing homes and board and care facilities.

- The New Hampshire MFCU played a lead role in successfully advocating for a newly established criminal neglect law that protects the elderly, people with disabilities and impaired adults. The purpose of the legislation is to fill a gap in the existing statutes governing assault crimes. The law provides for the first time a definition of "caregiver" and imposes a duty of care on those who meet that definition. Under the statute, neglect occurs when a caregiver fails to perform the functions expected of a person with the responsibilities set forth in the statute.

- In New York, state officials implemented regulations that now require non-licensed direct care nursing home and home care staff to undergo criminal background checks. The regulations require all agencies employing non-licensed employees who provide direct care to patients in nursing homes or through a home health care agency to conduct a Federal Bureau of Investigation (FBI) criminal background check on such applicants. The FBI checks are capable of providing criminal histories of prospective employees and would include information from all 50 states and the District of Columbia.

- The South Carolina MFCU suggested legislation requiring criminal record checks be made a condition of employment for nursing home staff. The state legislature passed the proposal and criminal background checks are now required for direct caregivers.

- Over the past several years, the Vermont Medicaid Fraud and Residential Abuse Unit has been spearheading an effort to pass legislation to enhance the criminal penalties for crimes against vulnerable adults. This year, "An Act relating to Criminal Abuse, Neglect, and Exploitation of Vulnerable Adults" was passed by the House and Senate and will become law. The purpose of the law is to move criminal abuse, neglect, and exploitation of Vulnerable Adults from the adult protective services civil/administrative statute into the criminal statutes. Most importantly, the bill provides for penalty enhancements for these crimes based on the seriousness of the injury and/or the monetary value of the exploitation. In current law, crimes against vulnerable adults in Vermont are only misdemeanors. Once the new law takes effect, law enforcement will be able to charge felonies in cases of serious abuse, neglect and exploitation of this highly vulnerable population.

- The Massachusetts Legislature passed a bill that increases criminal penalties for elder abuse and holds nursing home owners, operators and supervisors accountable for allowing patterns of abuse and neglect to occur in their nursing home facilities. Drafted by the Attorney General's MFCU, the law establishes the crime of indecent assault and battery upon an elder or person with a disability and assault and battery against an elder or disabled person, both containing enhanced penalties. The law also allows a civil case to be brought against a caregiver or supervisor who permits another to abuse, mistreat or neglect an elder or disabled person.

TRAINING

In many states, resident abuse cases are either reported directly to local law enforcement or may be referred to local authorities for prosecution. Training of law enforcement personnel to recognize and deal with resident abuse cases is an essential part of the MFCUs' mission, and many Units have developed and implemented such training and outreach programs. Others educate health care professionals, ombudsmen and the public to recognize and refer cases of resident abuse to the appropriate authorities.

- Under the Delaware MFCU's continuing statewide patient abuse training initiative, which began in 1998, MFCU investigators provide in-service training to each new Delaware Police Officer, as well as veteran Police Officers, nursing home and other long-term caregivers, senior citizen groups, Citizen Police Academy attendees, senior victim advocates and paramedics.

- The Hawaii MFCU continues its efforts to train, educate and network with front line responders, such as the Adult Protective Services (APS) of the Department of Human Services. APS is required to send all of its intakes and complaints to the MFCU. As a result, the MFCU is able to expeditiously review, investigate and prosecute all complaints and reports, many of which went unreported to any law enforcement agency prior to this agreement.

- A two year abuse and neglect awareness project of the Tennessee MFCU, the Tennessee Department of Health and Human Services' Adult Protective Service (APS) and the Tennessee Commission on Aging and Disability culminated with the public release of a video entitled "Unheard Cries." The video has been distributed to law enforcement and health care oversight agencies throughout the state and nation, together with informational brochures and posters.

- The Illinois MFCU provides on-site training regarding resident abuse and neglect to any facility or organization upon request.

- The Louisiana MFCU formed the Louisiana Patient Abuse and Neglect Action Committee (LAPANAC) as a means of partnering with other state and federal agencies and the health care community in an effort to heighten awareness and increase reporting of elder abuse.

- The Maryland MFCU has conducted sessions to train all Baltimore City Police Officers on issues relating to the investigation of abuse and neglect of vulnerable adults, with each session consisting of a presentation by an attorney and an experienced investigator. In addition, the Unit has held several Town Hall meetings to provide information to caregivers and others on patient abuse issues.

- The Montana MFCU is proactive in presenting training sessions to various provider and elder groups and continually presents training to nursing home staff regarding patient abuse. The Unit also makes presentations on patient abuse issues to other groups such as the aging council, volunteer ombudsmen and the AARP.
- Members of the Nevada MFCU are designing a curriculum on resident abuse and neglect for the University of Nevada.

- The Attorney General of Ohio convened an Elder Abuse Task Force comprised of various state, county and municipal organizations, which met monthly for one year to develop recommendations to improve the state's response to the growing issue of elder abuse. The task force recommended initiatives in the areas of policy, coordination and visibility, and its final recommendations were posted on the Attorney General's web site and presented to the Governor by the Attorney General in February 2005.

- The South Dakota MFCU helped to prepare a Senior Handbook on resident abuse issues, which was published by the Attorney General's office. In addition, the Unit provides instruction on resident abuse at the state law enforcement training center.

- The Pennsylvania MFCU conducts training sessions on the state's Neglect of Care-Dependent Persons statute and participates in a Medical-Legal Board about Elder Abuse and Neglect to identify and address cases of patient neglect around the state.

- The Rhode Island MFCU has presented numerous in-service trainings in nursing facilities throughout the state.

- The Utah Unit conducts monthly multi-disciplinary team meetings for organizations that work with vulnerable adult populations, and many of the cases discussed in these meetings are investigated by the Unit.

- The Washington State MFCU trains law enforcement personnel to recognize criminal mistreatment and resident abuse and to improve their response to such crimes. The Unit provides materials and conducts training regularly for the Basic Law Enforcement Academy and the Washington State Patrol Academy, provides a vulnerable adult training video to all Washington State law enforcement agencies for in-service training, and maintains and updates a network of contacts of all individuals in state law enforcement entities responsible for handling vulnerable adult and resident abuse allegations.

CONCLUSION

In closing, I want to emphasize that the Medicaid Fraud Control Units continue to play a national leadership role in detecting and prosecuting health care fraud and resident abuse. The Units have been successful in serving as a deterrent to health care fraud identifying program savings, removing incompetent practitioners from the health care system, and preventing physical and financial abuse of residents in health care facilities.

Thank you again for giving me the opportunity to testify today.

Testimony by Charles J. Milligan, Jr., J.D., M.P.H.

Executive Director
The Center for Health Program Development and Management
University of Maryland, Baltimore County

Before the
Committee on Finance
United States Senate

Hearing on
Medicaid Waste, Fraud, and Abuse: Threatening the Health Care Safety Net

June 28, 2005

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DEVELOPMENT AND MANAGEMENT

Introduction

Chairman Grassley, Ranking Member Baucus, and distinguished members of the committee, thank you for inviting me to appear before you today to discuss state Medicaid financing arrangements, such as intergovernmental transfer (IGT) and upper payment limit (UPL) financing arrangements that involve public hospitals and nursing facilities, as well as Medicaid school-based reimbursement.

My name is Charles Milligan and I am the executive director of the Center for Health Program Development and Management (Center) at the University of Maryland, Baltimore County (UMBC). The Center is a 55-person multi-disciplinary research and policy entity that works with public agencies and nonprofit community-based agencies in Maryland and elsewhere to improve the health and social outcomes of vulnerable populations through research, analysis, and evaluation. Since its inception in 1994, the Center has maintained a successful, nationally recognized partnership with the Maryland Department of Health and Mental Hygiene (Maryland's Medicaid agency) to analyze state health policies and help to develop solutions for the Maryland Medicaid program. Before taking my current position, for four years I was vice president at The Lewin Group, where I provided services to approximately twenty state Medicaid programs, working for both the legislative and executive branches of state government. Before that, I was the appointed Medicaid and S-CHIP director for the State of New Mexico, serving under Governor Gary Johnson.

As members of this committee, you are aware of the enormous toll Medicaid spending is exerting on the states. Between 2000 and 2003, growth in Medicaid spending (federal and state) averaged 10.2 percent annually, resulting in an increase in program expenditures by one-third in just three years. Medicaid spending increases were largely driven by enrollment growth, stemming in part from the economic downturn during that period. At the state level, annual Medicaid spending grew by an average of 11.3 percent, leading many states to implement cuts in Medicaid benefits, payment rates, and eligibility. In 2003, state Medicaid spending typically accounted for 21 percent of a state's expenditures, surpassing for the first time state expenditures for primary and secondary education.

In recent years, Medicaid enrollment has grown rapidly, now surpassing 50 million beneficiaries nationally. This growth in Medicaid enrollment occurred during a period marked by two other important factors—a rising rate in the uninsured, and federal support for safety net providers through programs like disproportionate share hospital (DSH) payments that was not indexed to the rising rate of Medicaid eligibles and the uninsured and therefore failed to keep up with the growing financial burdens faced by safety net providers such as public hospitals.

State use of special Medicaid financing techniques—such as reliance on IGTs to provide the state matching funds to pay public providers up to the Medicare UPL—clearly has increased. In my opinion, it is quite appropriate for Congress and the Bush Administration to look into these state practices, which in unusual cases may be the source of fraud and abuse. In doing so, however, it is important not to lose sight of the fact that states have pursued permissible IGT and

UPL practices in part as a response to the rapidly increasing demand for safety net services driven by growth in Medicaid enrollment and the uninsured.

Inextricably related to these special financing issues, the rapid increase in Medicaid costs has led to a major shift in the public discussion of Medicaid. In recent months, a consensus appears to be emerging among federal and state policymakers that Medicaid cannot be sustained in its current form. The basic Medicaid entitlement—that all beneficiaries must receive the same benefits and be subject to the same set of rules—is being questioned by state and federal policy makers, in a bi-partisan way. Now more than any time in recent history, reform may emerge in a dialogue that is and must be connected to the underlying fiscal discussion. Medicaid reform, if properly developed, may protect the mission of Medicaid and yet allow for meaningful change to Medicaid in a way that will preserve its long-term crucial role for the poor, people with disabilities, seniors, and others who depend on the Medicaid program. It is my sincere hope that Congress and the Bush Administration approach the Medicaid budget discussion and the Medicaid reform discussion as a single topic, rather than as two unrelated topics.

In my remarks that follow, I will describe how IGT and UPL financing arrangements work, demonstrate the enforcement challenges that would exist if the federal government sought to alter these arrangements, outline the benefits that accrue to safety-net institutions, and offer recommendations to redress the underlying risk for fraud and abuse in an alternative way. This will be followed by a discussion of similar considerations in the area of school-based reimbursement in Medicaid.

Intergovernmental Transfers and the Upper Payment Limit

No one disagrees that Medicaid provides an important safety net for the country's most vulnerable populations and the health care providers that serve them. Medicaid is an important source of financing for the nation's public hospitals, federally-qualified health centers, Indian Health Services, maternal and child health clinics, and others. Medicaid can account for as much as half of net patient care revenues for these providers. Similarly, many state- and county-owned nursing facilities have large Medicaid resident populations and are dependent on Medicaid revenue.

Moreover, it is crucial to not lose sight of the fact that Medicaid beneficiaries rely on these providers for their care. Ultimately, the financing arrangements developed by state and local governments that involve these public providers almost without exception are motivated by a desire to ensure access to care for Medicaid enrollees, and to some extent the uninsured.

It is the nation's public hospitals and state- and county-run nursing homes that are the primary beneficiaries of IGT and UPL financing arrangements. These financing arrangements have become more commonplace as states have endeavored to maximize federal matching dollars in response to caps in Medicaid DSH, at a time of rising rates of Medicaid enrollees and the uninsured.

In brief, an intergovernmental transfer, or IGT, is the movement of state or local tax revenues from one public agency to the Medicaid agency. The IGT could originate at a county government, which transfers funds to the state Medicaid agency. It could originate at a state health department, which would pass the funds to Medicaid. Other examples also exist. The IGT, then, is the source of the state or local matching funds, which are utilized by the Medicaid agency to draw down federal financial participation (FFP) at the given state's matching rate.

The Medicaid agency then uses these matched funds to increase the payment rate to a public provider affiliated with the governmental entity that supplied the IGT in the first place. This increase is in the form of a higher payment for an actual health care service provided to an actual Medicaid beneficiary. For example, the payment for a delivered service may increase from $100 to $150. The ceiling on Medicaid's payment to this public provider, roughly speaking, is what Medicare instead would have paid for the same service, had it been a Medicare claim for a Medicare beneficiary. Thus, the federal government, through the Medicare rates, sets the ceiling, or upper payment limit (UPL), on Medicaid's payments to hospitals and nursing facilities.

As described more fully below, the IGT (from a county government, for example) is the source of the state match, which, when matched with FFP, is used to increase the payment rates to a public provider (a county hospital, for example), which is related to the entity that provided the original IGT. UPL arrangements were estimated to total more than $11 billion in 2001.

In its budget proposal to Congress, the Bush Administration stated its concern that using IGT and UPL arrangements undermine the federal-state Medicaid partnership in two important ways: 1) in some financing arrangements, the federal matching rate appears to be effectively increased; and 2) payments to providers can exceed costs.

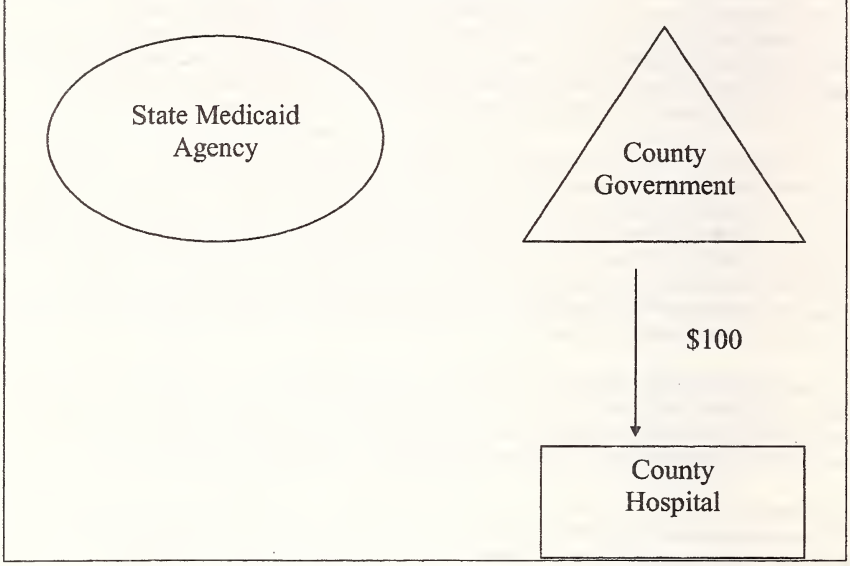
A 2002 survey of states reported in the March/April 2004 issue of the journal *Health Affairs* found that, in the 34 states responding, 56 percent of total federal and state UPL payments went to nursing facilities, primarily publicly-owned homes; 27 percent went to private or local hospitals; and 2 percent went to state or university hospitals. States received 80 percent of the UPL gains made available through nursing homes; most placed these gains in the Medicaid general fund. Clearly, IGT and UPL arrangements have proliferated, and have been used by states to finance the burden of rapidly rising Medicaid costs and costs related to indigent care.

In the discussion that follows, I describe how IGT and UPL arrangements work, step by step.

Starting Point: Pre-Medicaid Involvement

All examples use a case study of a county government and a county hospital. The same general approach applies to other intergovernmental arrangements. Exhibit 1 illustrates how a county government provides financing to a county hospital assuming no involvement with Medicaid. Funding for services provided (in this case, $100) is simply transferred directly from the county government to the county hospital with no involvement of the state Medicaid agency.

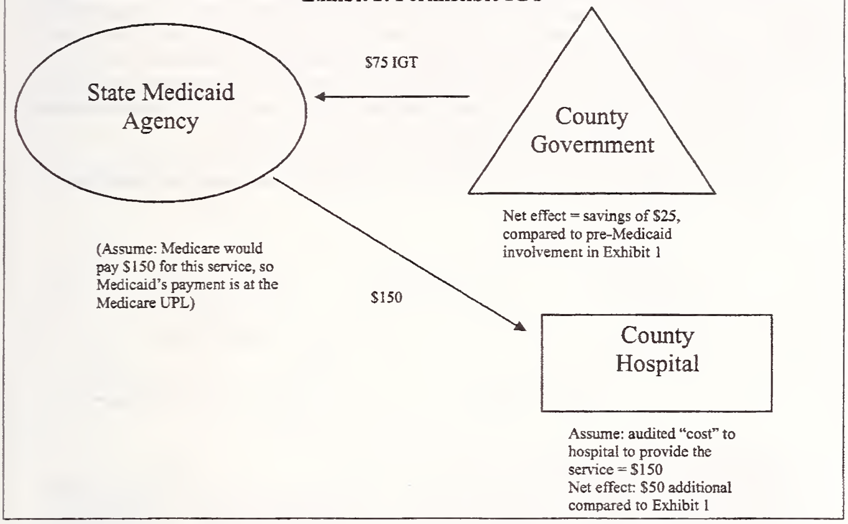
Exhibit 1: Pre-Medicaid Involvement



Permissible IGT
Exhibit 2 illustrates an arrangement that would be considered permissible under new rules proposed by the Bush Administration. Assume that the county hospital provides a service with a Medicare UPL of $150. The county government transfers $75 to the state Medicaid agency, the county's funds are matched 50/50 by the federal government, and the county hospital receives $150 for an actual service provided to a Medicaid beneficiary. This also assumes that the audited cost to the hospital to provide the service is at least $150. The outcome of this arrangement is that the hospital realizes a $50 net gain ($150 - $100) over the amount it would receive with no Medicaid involvement (Exhibit 1), and the county's financial burden has been eased by $25 compared to the original model. The total benefits of $75 ($50 to the county hospital, and $25 to the county government) are due to the infusion of $75 in federal Medicaid funds.

Unlike DSH, which may be a direct subsidy to a public hospital not linked to a health care claim or encounter, the IGT and UPL arrangement is premised on a Medicaid beneficiary receiving a service for which the county hospital submits a claim to Medicaid, and is paid at the rate of $150.

Exhibit 2: Permissible IGT

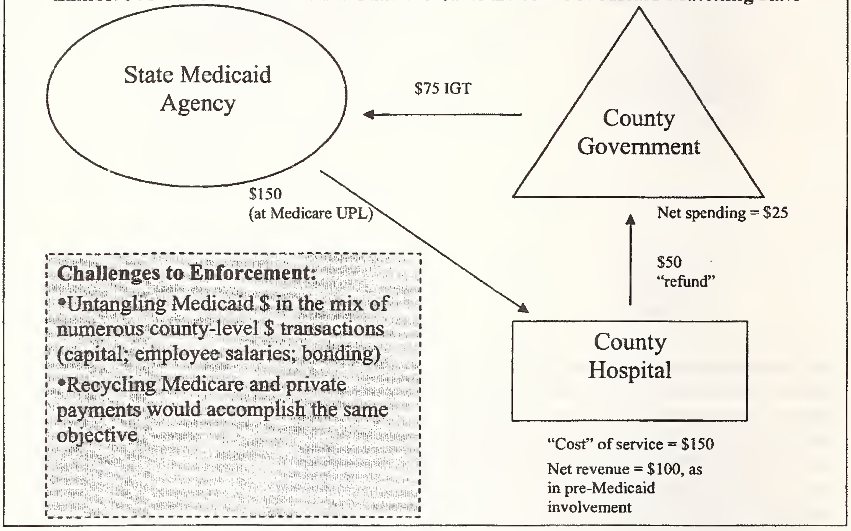

State Medicaid Agency
$75 IGT
County Government
Net effect = savings of $25, compared to pre-Medicaid involvement in Exhibit 1
(Assume: Medicare would pay $150 for this service, so Medicaid's payment is at the Medicare UPL)
$150
County Hospital
Assume: audited "cost" to hospital to provide the service = $150
Net effect: $50 additional compared to Exhibit 1

Not Permissible—Violation of IGT Rule by Increasing Effective Federal Matching Rate
Exhibit 3 shows an IGT arrangement that would be defined by the Bush Administration as effectively raising the federal-state matching rate to 75/25, which would not be permissible under the IGT provision of the Bush Administration's proposal. Again the county government transfers $75 to the state Medicaid agency, the county's funds are matched 50/50, and the county hospital receives $150 for the service. Then, $50 is "recycled" back to the county government. The county government's net spending therefore is $25 ($75 - $50). Thus, the recycling results in an effective match rate of 75/25 (the net county contribution of $25 generates $75 in FFP).

Even if recycling is rampant, a proposition for which there is not yet concrete evidence, it will be extremely difficult for the Bush Administration to enforce a ban on the "recycling" of funds. The financial relationships between the county government and the hospital are so replete (new bonds for capital to build a new wing; county funds for employees' wages and benefits; hospital purchasing of county-level administrative services; joint purchasing of utilities; etc.) that it would be extremely difficult to isolate Medicaid funds in the overall traffic of money moving between the county government and hospital. But assume the Administration was able to ban the recycling of Medicaid funds successfully. Presumably, the hospital still could send other funds to the county government (for services provided to privately insured patients that led to funds from private insurance companies, for example) that would accomplish the same overall objective.

Last, it must be noted that every state's overall tax structure is unique—some states have no state income tax and instead rely on property or sales taxes. In some states, the tax burden is borne at the local level, because local government traditionally has held the main strong service role for health care delivery. In other states, the tax burden and primary role for health and social services is borne at the state level. If the federal government were to bar local funds from inclusion in Medicaid financing by banning IGTs in a state where local taxation and a strong local government role is traditional, it would run the risk that the federal government would be endorsing one form of state tax structure (central collection at the state level) over others, which might be perceived as an inappropriate federal intrusion into state tax policy.

Exhibit 3: Not Permissible—IGT That Increases Effective Medicaid Matching Rate


State Medicaid Agency
$75 IGT
County Government
$150 (at Medicare UPL)
Net spending = $25
$50 "refund"
Challenges to Enforcement:
•Untangling Medicaid $ in the mix of numerous county-level $ transactions (capital; employee salaries; bonding)
•Recycling Medicare and private payments would accomplish the same objective
County Hospital
"Cost" of service = $150
Net revenue = $100, as in pre-Medicaid involvement

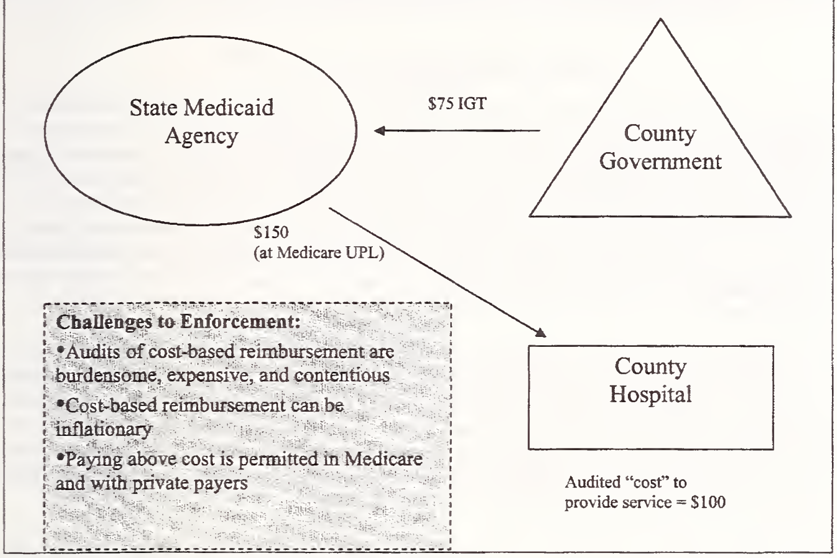
Not Permissible—Violation of UPL by Reimbursing Above Actual Cost

Exhibit 4 demonstrates an arrangement that would violate the Administration's proposal that seeks to limit Medicaid reimbursement to the lower of Medicare or the actual cost of providing services. At present, the second half of this test, restricting payments to no more than cost, does not exist. In Exhibit 4, the county government is paid $150 (what Medicare would have paid for the same service). However, assume the actual cost to provide the service is $100. In the new UPL test, which would limit Medicaid payments to the lower of Medicare *or* actual cost, the $150 payment is impermissible since it exceeds the cost to the county hospital by $50.

Again, it may prove to be difficult for the Bush Administration to enforce this rule. To do so, it would be incumbent on the provider to create auditable cost reports to isolate the cost of serving its Medicaid beneficiaries, and Medicaid agencies then would have to audit these cost reports. This reimbursement model, similar to the rule under the Boren Amendment that was repealed by

Congress in the 1997 Balanced Budget Act, is administratively burdensome, expensive, and often contentious as states and providers argue over whether certain costs should be allowed. Moreover, cost-based reimbursement can exert inflationary pressures, as providers are penalized for efficiency. In addition, Medicaid alone would be singled out for this cost-based test—the hospital still could bill Medicare for the full $150 and be paid at this full rate. It is unclear why Medicaid should not be allowed to pay what Medicare pays for the identical service.

Exhibit 4: Not Permissible—UPL Limits Reimburse to Actual Costs



Challenges to Enforcement:

- Audits of cost-based reimbursement are burdensome, expensive, and contentious
- Cost-based reimbursement can be inflationary
- Paying above cost is permitted in Medicare and with private payers

A Better Approach to Addressing the IGT and UPL Financing Arrangements

Without a doubt, there is a risk of fraud and abuse in IGT and UPL arrangements, and it is fully appropriate for Congress and the Bush Administration to view these arrangements with a measure of skepticism and a clear focus on their fiduciary duty to federal taxpayers. Yet the magnitude of the actual problem cannot be accurately quantified, and it is important to note that these tools are used by states and local governments to maximize federal matching payments as a strategy to redress the fiscal challenges related to DSH caps, which have not kept up with the growth in Medicaid enrollment and the uninsured.

I would like to offer two alternative strategies for addressing IGT and UPL financing arrangements: first, the cleanest way for the federal government to exert control is to lower the size of the actual Medicaid payment for a given service to the county hospital (in my example throughout this testimony). This avoids both the impossible task of tracing dollars after receipt by the provider, and it avoids the administrative expense and burden of audited cost reports. This is best accomplished by focusing on Medicare's payment to hospitals as the ceiling. If Medicare's payment is too high, and therefore sets a Medicaid ceiling in the UPL that is too high, the cleanest approach is to tackle Medicare's fees. Second, much of the incentive to engage in IGT and UPL arrangements would be dissipated if DSH payments were indexed to Medicaid enrollment and estimates of the number of people who are uninsured. Reviewing the role of DSH in this discussion could help alleviate this "gaming" by states, counties, and hospitals.

Medicaid School-Based Reimbursement

The issue of Medicaid reimbursement for school-based services follows a similar pattern to the IGT/UPL discussion. Under the federal Individuals with Disabilities Education Act (IDEA), school districts are obligated to provide certain therapies and other services to children requiring special education. Absent Medicaid funding, the school districts would be furnishing these services entirely with local school funding, typically from property tax revenue. However, because many of these children are on Medicaid, and because therapies are covered Medicaid services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provision of Medicaid, states and school districts have sought to secure FFP when school districts deliver special education health care services to Medicaid-enrolled children.

The controversy arises in the methodology by which school districts are paid for these services. Because school districts are not primarily health care providers, they are not typically organized to bill insurers like Medicaid on a claim-by-claim basis for individually covered services. That is, although they presumably could bill *any* insurer for providing a covered health care service to a covered child, school districts are not set up to submit claims using CPT codes. Therefore, most Medicaid reimbursement arrangements for school-based services are developed using a fairly complex cost-based reimbursement model.

This model often uses a time-study to determine the allocation of staff time necessary to provide speech therapy, for example, to children in special education. This time study would capture not only the therapist's time, but perhaps a small piece of time by the school secretary to do scheduling, and small amounts of time from others in the school as well, whose work facilitates the therapy. Then these pieces of time from many individuals are converted to a cost by using their respective salaries, benefits, and other direct and indirect costs. All of these allocations then determine that a single speech therapy visit might "cost" $75, for example.

To oversimplify a little, the Bush Administration is concerned that some school-based reimbursement methodologies overstate the overall costs and the time required by school staff members to support special education, because both the school and the Medicaid agency share an incentive to maximize federal Medicaid funds. This concern has been amplified by the presence of certain consultants, who might be paid a contingency percentage of the amount of federal Medicaid funds received in a successful Medicaid school-based financing arrangement.

This is another area where federal oversight and scrutiny certainly is warranted, in the interest of protecting federal taxpayers. At the same time, however, many of the concerns could be addressed by acknowledging that (a) schools are being asked to serve more and more children in special education without commensurate increases in federal funds, (b) Medicaid reimbursement for school-based services is allowable under EPSDT, so the real focus should be on establishing clear guidelines on what reimbursement methodologies are permissible, (c) most consultants are ethical, and are providing services not dissimilar from tax accountants who assist taxpayers in (legally) maximizing their funds; and (d) states generally have been operating in accordance with the methodologies contained in federally-approved Medicaid state plan amendments.

Conclusion

The risk to the federal Medicaid treasury in IGT, UPL, school-based reimbursement, and other areas traditionally involves situations where state or local governmental entities act as Medicaid providers, and the source for state matching funds is a state or local unit of government with a close relationship to that governmental health care provider. It is appropriate for Congress and the Bush Administration to review these arrangements. Still, it is crucial to retain the perspective that states generally have been acting in accord with legal reimbursement standards, and states and local governmental entities have been motivated by a goal of serving the rapidly growing number of Medicaid eligibles.

In addition, as the Medicaid rolls swell and state and federal policymakers grapple with the effect of this expansion on the government, it is vitally important to link, rather than delink, the fiscal objectives with the overall Medicaid policy reform discussion that hopefully will be engaged.

Thank you for the opportunity to share my remarks with you. Please know that I stand ready to assist you in any way that I can as you consider proposals to reform the Medicaid program.

Testimony of James W. Moorman, President and CEO
Taxpayers Against Fraud
on
The False Claims Act and Fraud Against Medicaid by Drug Manufacturers
before the
Senate Finance Committee
6/28/2005

Mr. Chairman and Members of the Committee, thank you for inviting me to testify at this important and timely hearing. We are in a situation where Congress is wrestling with whether to reduce Medicaid spending. Several states have done so and others are currently debating the issue. This is very painful because Medicaid is essential to the financing of needed health care for over 58 million low-income Americans. It is therefore imperative that savings in Medicaid come at the expense of those who have enriched themselves by defrauding the program. The False Claims Act has already demonstrated its ability to uncover complex corporate fraud against Medicaid and to return ill-gotten gains to the federal and state treasuries. The purpose of my testimony today is to explain the results that the False Claims Act has already achieved, why it is effective, and how the Federal Government can make it even more effective, generating concrete savings for the federal and state governments without harming low-income beneficiaries or honest providers.

First, let me introduce myself and my organization. My name is James W. Moorman and I am the President of Taxpayers Against Fraud, also known as TAF or as The False Claims Act Legal Center, a position I have held for the past five years. I am an attorney by training and served as an Assistant Attorney General of the Department of Justice under Attorneys General Griffin Bell and Benjamin Civiletti. Between my service at Justice and TAF, I was a partner in the law firm of Cadwalader, Wickersham & Taft.

Taxpayers Against Fraud and its sister organization, Taxpayers Against Fraud Education Fund, are non-profit charitable organizations dedicated to combating fraud against the Federal Government through the promotion of the use of the *qui tam* provisions of the False Claims Act, 31 U.S.C. §§ 3729- 33 ("FCA"). *Qui tam* is the singular mechanism in the FCA that allows persons with evidence of fraud in federal programs or contracts to bring suit on behalf of the federal government. Under the FCA, those that commit fraud are subject to treble damages and civil penalties. To encourage whistleblowers to come forward, the FCA provides that they share between 15 and 30 percent of the federal government's recoveries. I would like to note for the record that neither TAF nor TAF Education Fund has ever received any support from PhRMA or any drug manufacturer.

Thanks in large part to the tireless efforts of Chairman Grassley, the public over the past few years has become more aware of the effectiveness of the FCA and its whistleblower provisions in curbing Medicare fraud. In press releases and public statements, the Chairman has highlighted important settlements and other achievements that have returned over $4 billion to the Medicare trust fund to date. As health economist Jack Meyer concluded in a report just released by TAF Education Fund, Fighting Medicare Fraud: More Bang for the Federal Buck, April 2005, the federal government has realized $13 in direct recoveries for every $1 it has invested in investigating and prosecuting Medicare fraud through the FCA.

The role of the FCA is curbing Medicaid fraud is less well understood, which is one reason why today's hearing is so important. In 2003, the TAF Education Fund published a report authored by Andy Schneider explaining the potential of the FCA to reduce Medicaid fraud. Since that report was published, the FCA has clearly established itself as a potent tool against Medicaid fraud, returning about $1.2 billion to the federal and state treasuries over the past 5 years. Whistleblower lawsuits under the FCA have uncovered fraud in a variety of industries in the health care sector of the economy, ranging from hospitals to nursing homes to clinical laboratories to chain drug stores. However, by far the largest share of recoveries—about 80 percent—have resulted from cases involving pharmaceutical manufacturers.

As of the end of FY 2004, there were ten settlements of FCA cases brought by whistleblowers alleging false or fraudulent claims against Medicaid by pharmaceutical manufacturers. (There have been no reported settlements so far in FY 2005). These ten settlements, which involved three different types of fraudulent conduct, returned $535 million to the federal treasury and $413 million to state treasuries in satisfaction of losses to the Medicaid program. A number of these cases also involved allegations of false or fraudulent claims against the Medicare program. Total recoveries in these ten cases to Medicare and Medicaid, plus criminal fines, totaled $2.5 billion. The Appendix contains tables and figures summarizing these settlements.

In addition to the direct recoveries, these settlements have had an important indirect effect. Pharmaceutical manufacturers now have a much better appreciation of the importance of full compliance with the reporting requirements of the Medicaid drug rebate program. Given the volume of drugs that Medicaid buys—it is the nation's single largest drug purchaser, accounting for 18 percent of all drug spending—the difference between partial and full compliance can literally mean hundreds of millions of dollars in savings to the federal and state governments each year. Even after Medicare Part D is launched next January, Medicaid will still account for 9 percent of the nation's drug spending—no small matter in a market expected to grow to $249 billion next year.[1]

The deterrent effect of the FCA has not been quantified, but to appreciate its potential, consider the following: We know from CMS data that during this fiscal year (2005) manufacturers will pay almost $10 billion in rebates to Medicaid. It would be reasonable for one to assume that the deterrent effect of FCA cases is at least 10 to 15 percent of expenditures. That is, one could reasonably assume manufacturers would pay 10 to 15 percent less in rebates if they operated in a world without the whistleblower provisions of the FCA. On this conservative assumption, the FCA is worth between $1 to $1.5 billion in additional annual rebates to the federal and state governments. Of course, the FCA's deterrent effect may be significantly higher than 10 to 15 percent. If so, these savings would increase accordingly. Under any scenario—other than no deterrent effect, which is simply not plausible—the savings to federal and state taxpayers are significant.

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[1] S. Heffler et al., "U.S. Health Spending Projections for 2004-2014," *Health Affairs Web Exclusive* (February 23, 2005), Exhibit 5.

Why has the FCA been so successful in uncovering complex corporate fraud on the part of some drug manufacturers against Medicaid? The answer lies in the amendments authored by Chairman Grassley in 1986, which incentivized whistleblowers to come forward with inside information about fraud against government programs despite the threat of retaliation. When the management of a firm develops a business plan to take advantage of a large government program like Medicaid, the company usually takes steps to cleverly mask what they are doing from the federal and state officials that administer the program. FBI "sting" operations have been successful at uncovering some of these fraudulent business plans. As a practical matter, however, by far the most effective source of information about such plans is whistleblowers.

The $257 million settlement with Bayer Corporation in 2003 is a classic example. In 2003, Bayer agreed to pay $251 million in civil recoveries and $5.6 million in criminal fines to settle allegations of fraud against the Medicaid program in connection with marketing of the antibiotic Cipro and the blood pressure medicine Adalat CC. The allegations were that Bayer underpaid Medicaid rebates owed to the federal and state governments by concealing deeply discounted prices that it gave on these products to managed care plans in order to have the drugs included in the plans' formularies. The concealment technique, known as "lick and stick," was very clever. Bayer placed the managed care plan's NDC number on the label of the drugs it sold the plan rather than its own. Though manufacturers are required to report prices to the Medicaid rebate program by their own NDC numbers, Bayer did not report the prices it was giving to the managed care plans to the federal government for purposes of calculating the "best price" rebate amount. Neither Bayer nor the managed care plans disclosed the actual deep discounts. The federal government would almost certainly never have found out about it but for the whistleblower, the late George Couto, then a Bayer marketing executive, who was troubled by his employer's conduct. Couto's disclosures also led to an $88 million settlement by GlaxoSmithKline foe similar conduct.

FCA cases filed by whistleblowers have become our main hope for curbing drug manufactures' Medicaid cheating. In addition to the 10 settlements that have occurred so far, there are a large number of additional cases against drug manufacturers that have been brought by whistleblowers. Mr. Peter Keisler, the Assistant Attorney General for the Civil Division of the U.S Department of Justice told the Wall Street Journal (See P.1, June 7, 2005) that the Department was aware of 150 more such cases, which he said involved nearly 500 different drugs. Because of specific requirements of the False Claims Act, these cases are under seal and public information about most of them is unavailable. Nevertheless, there is no doubt that these cases exist.

With regard to these cases, we at TAF believe the following to be true:

- Many of the cases are being handled by the U.S. Attorney offices in Boston and Philadelphia, though others are scattered around the country, venued in other U.S. Attorney offices.
- Many of these cases involve damages in the nine-figure range. The total value of these cases could be in the neighborhood of $25 billion dollars.
- The number 150 is a low number because it does not include cases filed in state courts, under state False Claims Acts. Because Medicaid cases involve Fraud against states as well as the federal government, federal FCA cases are frequently mirrored by one or more state FCA cases. In addition there are a number of cases filed by state attorneys general involving Medicaid fraud by drug manufactures that rely on other fraud statures. Overall the number of federal and state cases against drug manufactures for cheating Medicaid could be as high as 200 to 250.
- The Department of Justice appears to be having difficulty resolving these cases in a timely fashion. Though these cases are numerous, only three were resolved in FY 2004 and none have been resolved in the first half of FY 2005. Based on conversations I have had with lawyers on a confidential basis (conversations which did not breach the requirements of the seal provisions of the False Claims Act), the members of the private bar representing whistleblowers in these cases are deeply concerned that the Department of Justice's lawyers assigned to drug manufactures cases are seriously overburdened. The number of lawyers assigned to handle these cases and the collateral support for the cases appears to be insufficient.

This brings me to what this committee can do to further the FCA program to curb Medicaid fraud by drug companies.

First, this committee can take action to enhance the resources devoted to the FCA litigation. This can be done by increasing and/or re-adjusting the allocation of the money provided to the Health Care Fraud and Abuse program (HCFAC) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for FCA litigation support. More HCFAC money needs to be devoted to the Justice Department's health care False Claims Act cases in general and to the cases against drug manufacturers in particular. As I understand it, $240 million is now provided each year to DoJ and HHS under the HCFAC program. This money originates mostly from FCA health care fraud settlements and judgments (the FBI apparently gets a separate $114 million to investigate health care fraud.[2]) The $240 million is allocated each year by the Attorney General and the Secretary of HHS. Based on the Annual HCFAC Report for FY 2003 and TAF's recently released report on Medicare Fraud by Jack Meyer, the following amounts were provided to the following components of the government in FY 2003[3]:

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[2] Government Accountability Office, *Federal Bureau of Investigation: Accountability over the HIPAA Funding of Health Care Fraud Investigations is Inadequate*, GAO-05-388 (April 2005).

[3] The amounts reported by Meyer are consistent with those subsequently determined by the Government Accountability Office, *Heath Care Fraud and Abuse Control Program: Results of Review of Annual Reports for Fiscal years 2002 and 2003*, GAO-05-134 (April 2005), Figure 2, p. 11.

1. DoJ's Civil Division is at the center of the FCA litigation program. In FY 2003, Civil spent $17.5 million on heath care fraud cases, of which $14.5 million came from HCFAC. It is our view that this in not nearly enough for the Civil Division and that at least an additional $10 million should be provided to the Civil Division to support the drug company cases and other health care FCA cases.
2. The U.S. Attorney Offices spent $76.3 million on heath care related civil fraud cases in FY 2003, of which $30.4 came from HCFAC. It is our view that two things need to be done with regard to the U.S Attorneys Offices:

   First, a review should be made to determine whether the HCFAC money is allocated to the offices carrying the big health care FCA cases. I understand an allocation was made of the positions supported by HCFAC in 1997 before the big caseload arose and that that allocation has not been revised since.

   Second, we believe another $25,000,000 should be allocated to the U.S Attorneys Offices with significant civil health care fraud dockets.

3. HHS should spend more of its HCFAC money to support FCA litigation. HHS gets by far the largest share of the HCFAC fund at $191 million (in FY 2003), of which $160 million went to the Office of Inspector General and $23.3 million went to CMS. However, not enough of that money is being used to support the crucial civil fraud litigation. Thus, in FY 2003, OIG may have spent only $9.5 million and CMS may have spent nothing to support the FCA litigation. The FCA provides the government with the largest recoupment of health care money diverted by fraud. Also, False Claims Act cases are returning $13 for every $1 dollar invested in FCA litigation. Under these circumstances, it seems sensible for OIG to spend a more significant amount of its money to support the FCA cases.

Second, as Chairman Grassley has suggested in his August 2004 letter to PhRMA, firms receiving large amounts of federal Medicaid or Medicare funds should be required to provide basic information about the FCA to their employees. TAF believes this idea has merit. If the management of companies that receive significant amounts of money from Medicaid (and Medicare) were to educate their employees in the workings of the FCA, they would be far less tempted to devise business plans that involve fraud. This deterrent effect could save large amounts of money. When employees understand that the submission of false or fraudulent claims to the federal government is against the law, and that violation of the law gives rise to civil liability for their employer, they will be less likely to engage in such conduct or to tolerate such conduct by other employees. We recommend that the Committee build upon Senator Grassley's idea by requiring all large entities receiving more than $1 million per year in federal funds under Medicare or Medicaid to provide basic information about the FCA and its *qui tam* provisions to their employees on an annual basis.

No doubt the drug manufactures and other health care providers will resist this idea. They have already advanced a number of reasons in opposition the FCA, which, in essence boil down to two things. First, they argue that whistleblowers are unworthy people – that they are bounty hunters, that they participate in the frauds, or that they are vindictive about unrelated problems they are having with their employer. But whether or not such charges are true in any individual case, these things are beside the point where significant fraud is uncovered. The second argument is that use of the FCA disrupts companies' internal compliance programs and to encourage FCA cases will make it harder for the companies to suppress fraud. However, this argument only suggests that many companies are in denial. Very large frauds are being uncovered which could not have occurred without management approval or acquiescence. Current compliance programs may be well intended, but they cannot suppress large-scale business plans frauds, because the frauds have the support of those who have the authority to remedy the frauds.

Third, the Medicaid statute should be amended to require all states, as a condition of receiving federal Medicaid matching funds, to put in place their own false claims acts with whistleblower provisions. This is necessary because the FCA only applies to fraud against the federal government, not the states, and therefore does not cover the states' share of Medicaid spending. Passage of state FCAs will plug this loophole.

Some states have enacted their own false claims acts with *qui tam* provisions that reward whistleblowers with a share of the state portion of recoveries in cases of Medicaid fraud. Currently, thirteen states and the District of Columbia have enacted such laws: California, Delaware, Florida, Hawaii, Illinois, Louisiana, Massachusetts, Nevada, New Hampshire, New Mexico, Tennessee, Texas, and Virginia. These states account for about 35 percent of all federal Medicaid spending.

The enactment of FCAs by the remaining states would generate Medicaid savings for the federal government for three reasons. One, the existence of a state FCA, and the financial incentives at work in its *qui tam* provisions, supplements the incentives in the Federal FCA for whistleblowers to file actions involving fraud against the Medicaid.

Two, the availability of a state FCA increases the procedural options for the filing and prosecution of Medicaid fraud cases. For example, if DoJ is unable, due to staffing constraints or competing priorities, to investigate a case, the availability of a state FCA in this situation means that, in the absence of DoJ activity, a state Attorney General can bring his or her own investigative resources to bear.[4] Also, the filing of state FCA cases can stimulate the federal government to pursue fraud feasors that might otherwise be neglected.

Third and finally, there is the deterrent effect of state FCAs—difficult to quantify but impossible to discount. In states like Texas, where the Attorney General has publicized state FCA settlements and made clear that additional cases would be brought as necessary, Medicaid providers have yet another reason to file only accurate claims.[5] Certainly, after two large settlements totaling $45 million and a public commitment by the Attorney General to bring similar cases as needed, only the most foolish drug manufacturer would continue to inflate prices reported to the Texas Drug Vendor Program.

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[4] The Medicaid Fraud Control Units focus most of their resources on criminal fraud against the program. By making the State Attorney General responsible for investigating whistleblower cases, a state FCA has the practical effect of increasing the staff allocated to civil Medicaid fraud matters. These investigative costs are often financed with proceeds from the state FCA settlements.

Some may be concerned that such a requirement would constitute a mandate on the states. There is no question that, under our proposal, the 37 states representing 65 percent of all Medicaid spending that do not currently have a state FCA in place would have to enact such legislation. However, Federal Medicaid law already requires states to enact certain laws that achieve savings, such as laws relating to medical child support [6] and giving a state the right to payment from legally liable third parties (principally insurers) for payments made to health care providers by Medicaid.[7] Just as these requirements were designed to achieve Medicaid savings for both the state and federal governments, so would be a requirement that each state have an FCA with *qui tam* provisions.

In sum, requiring all states to enact FCAs with whistleblower provisions will reduce federal Medicaid funds lost to fraud. It will also reduce state Medicaid funds lost to fraud. Most importantly, such a requirement would enable both levels of government to save money on Medicaid without cutting eligibility or benefits or provider reimbursement.

Thank you again for the opportunity to testify today. I would be pleased to answer any questions.

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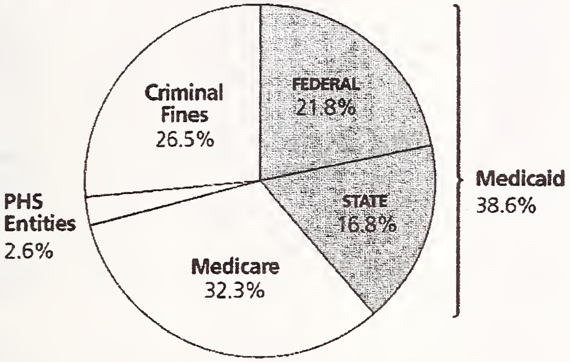
[5] *Attorney General Abbott Sues Three More Drug Makers in Multimillion Dollar Whistleblower Fraud Case* (May 26, 2004) http://www.oag.state.tx.us/oagnews.

[6] Sections 1902(a)(60) and 1908A of the Social Security Act.

[7] Section 1902(a)(25)(H) of the Social Security Act.

Figure 1 Disposition of Recoveries in Cases for Drug Pricing Fraud in Medicare and Medicaid (FY 2001 – FY 2004)



TOTAL = $2.458 Billion

Source: Settlement agreements on file at TAF Education Fund library

Table 1 Whistleblower Cases Under Federal and State FCAs Settled with Prescription Drug Manufacturers as of September 30, 2004

Company	Settlement Date	Product	Total Recovery	Type of Alleged Fraud	Whistleblower
AstraZeneca	6/20/03	Zoladex (prostate cancer)	$355 million	Marketing the spread Concealment of "Best Price"	Sales executive of competitor TAP Pharmaceuticals
Bayer I	1/23/01	Kogenate, Koate-HP (hemophilia) Gamimmune (immune deficiency)	$14 million	Marketing the spread Concealment of "Best Price"	Specialty pharmacy (same as Dey, Schering-Plough I)
Bayer II	4/16/03	Adalat CC (blood pressure) Cipro (antibiotic)	$257 million	Concealment of "Best Price"	Bayer marketing executive
Dey*	6/11/03	Albuterol Sulfate and Ipratropium Bromide (asthma inhalants)	$18.5 million	Marketing the spread	Independent pharmacy (same as Bayer, Schering-Plough I)
GlaxoSmithKline	4/16/03	Paxil (anti-depressant) Flonase (nasal allegy spray)	$88 million	Concealment of "Best Price"	(derived from Bayer marketing executive allegations)
Pfizer I	10/28/02	Lipitor (cholesterol)	$49 million	Concealment of "Best Price"	National account manager for Pfizer subsidiary
Pfizer II	5/13/04	Neurontin (anti-seizure for epilepsy)	$430 million	Off-label marketing	Medical liaison to physicians for Pfizer subsidiary
Schering-Plough I*	5/3/04	Albuterol drugs (asthma inhalants)	$27 million	Marketing the spread	Specialty pharmacy (same as Bayer, Dey)
Schering-Plough II	7/29/04	Claritin family of products (non-sedating antihistamines)	$345 million	Concealment of "Best Price"	Three employees at Schering-Plough subsidiary
TAP Pharmaceuticals	10/3/01	Lupron (prostate cancer)	$875 million	Marketing the spread Concealment of "Best Price"	HMO physician and TAP sales executive

* Settled under the False Claims Act and the Texas Medicaid Fraud Prevention Act

Table 2 Recoveries in Whistleblower Cases Against Pharmaceutical Manufacturers (Settlements as of September 30, 2004)

Manufacturer (settlement date)	Total Recovery	Criminal Fine	Medicare Recovery	Total Medicaid Recovery	Federal Medicaid Recovery	State Medicaid Recovery	Relator's Share
AstraZeneca (6/20/03)	$355 million	$63.9 million	$266.1 million[21]	$24.9 million	$13.7 million	$11.2 million	$47.6 million
Bayer I (1/23/01)	$14 million	None	None	$14 million	$7.8 million	$6.2 million	$1.6 million
Bayer II (4/16/03)	$257 million[22]	$5.6 million	None	$242.1 million	$133.2 million	$108.9 million	$34.2 million
Dey (6/11/03)	$18 million[23]	None	None	$14.8 million	$9.2 million	$5.6 million	$3.2 million
GlaxoSmithKline (4/16/03)	$88 million[24]	None	None	$85.1 million	$46.8 million	$38.3 million	None
Pfizer I (10/28/02)	$49 million	None	None	$49 million	$27.9 million	$21.1 million	$5.9 million
Pfizer II (May 13, 2004)	$430 million[25]	$240 million	None	$152 million	$83.5 million	$68.4 million	$24.6 million
Schering-Plough I (5/3/04)	$27 million[26]	None	None	$27 million	$12.4 million	$9.2 million	$5.4 million
Schering-Plough II (7/29/04)	$345.5 million[27]	$52.5 million	None	$282.4 million	$165.3 million	$117.1 million	$31.7 million
TAP Pharmaceuticals (10/3/01)	$875 million	$290 million	$528.3 million	$56.7 million	$31.2 million	$25.5 million	$95.1 million
Totals	**$2.458 billion**	**$652 million**	**$794.4 million**	**$948 million**	**$534.9 million**	**$413.1 million**	**$249.3 million**

Source: Settlement agreements on file at TAF Education Fund library.

Note: Totals for Federal and State Medicaid Recovery columns adjusted by allocating $5.4 million relator's share in proportion to Texas federal matching rate of 60 percent.

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[21] This amount includes payments to settle claims by TRICARE and Department of Defense.

[22] This amount includes Bayer payments to PHS entities of $9.5 million.

[23] This amount includes $2.3 million in attorneys' fees and costs to relator and to state of Texas.

[24] This amount includes GSK payments to PHS entities of $2.6 million.

[25] This amount includes Pfizer payments of $38 million to states for harm to consumers and to fund remediation program.

[26] This amount includes $5.4 million payment for relator's share and attorneys' fees and costs presented in "Relator's Share" column.

[27] This amount includes Schering-Plough payments to PHS entities of $10.6 million.

Sources

Background Information on Medicare and Medicaid Fraud available from Taxpayers Against Fraud Education Fund (TAFEF) at www.taf.org

J. Meyer, *Fighting Medicaid Fraud: More Bang for the Federal Buck.* (April 2005)

A. Schneider, *The Role of the False Claims Act in Reducing Medicare and Medicaid Fraud by Drug Manufacturers: An Update* (November 2004)

A. Schneider, *Reducing Medicare and Medicaid Fraud by Drug Manufacturers: The Role of the False Claims Act* (November 2003)

J. Meyer, *Fighting Medicare Fraud: More Bang for the Federal Buck* (June 2003)

A. Schneider, *Reducing Medicaid Fraud: The Potential of the False Claims Act* (June 2003)

J. Meyer and S. Anthony, *Reducing Health Care Fraud: An Assessment of the Impact of the False Claims Act* (September 2001)

TAFEF also publishes the *False Claims Act and Qui Tam Quarterly Review*, which provides an overview of major FCA and *qui tam* developments involving health care and other fraud against the federal government, including case decisions, DOJ interventions, and settlements.

Erickson®
Retirement Communities

Testimony of Daniel K. O'Brien, Senior Vice President, Erickson Retirement Communities

United States Senate Finance Committee
June 29, 2005

Mister Chairman and Members of the Committee, I am pleased to have the opportunity to testify today on behalf of Erickson Retirement Communities. I applaud the committee for taking on this important issue and I am hopeful that our experience will provide insight into some of the problems surrounding long term care and, more importantly, some immediate steps that can be taken by the Committee to restore some equity and fairness to the Medicaid program.

Erickson Retirement Communities ("Erickson") develops and manages non-profit continuing care retirement communities in nine states. The Erickson network is home to over 16,000 middle-income seniors nationwide. Erickson is one of the most innovative and fastest growing senior housing and health care providers in the nation. Our model of health care delivery is both unique and resident-focused. We can report both better health care outcomes for our residents as well as increased overall satisfaction in their quality of life. We are proud of the fact that we deliver high quality service to our residents at prices that are affordable to seniors of moderate means. However, our model is being threatened by creative attorneys who have counseled their clients to do an end run around the system, inappropriately shifting their assets in a manner that increase the cost to our residents and further strain state Medicaid budgets without any corresponding increase in quality.

Asset Shifting

The overall health of the Medicaid program, especially the costly long-term care component, is increasingly a crisis at the Federal and state levels. Despite rising enrollment and escalating costs, Federal and state policy continues to permit middle-income and wealthy seniors or their adult children to manipulate complex Medicaid eligibility rules and inappropriately shift the costs of their care to the American taxpayer.

Key Points:

1. Current law and practice places the inheritance interests of adult children – at least for those who are sophisticated enough to game the system -- ahead of the real reason Medicaid exists, to provide a high quality health care system to the truly needy.

2. Congress can debate whether it is appropriate to pay for the nursing care of all of its citizens – rich, middle-income and poor alike. However, under current law, the limited resources available to care for those Americans who are genuinely in need are being siphoned off to enhance the inheritances the families of seniors who are wealthy and sophisticated enough to hire an attorney to game the system. Only the middle-class and those whose sense of public responsibility requires them to do so pay their own way. This seems patently unfair.

3. Current law and practice stifles innovation and the creation of high quality settings that are affordable to seniors of moderate means. Health care providers are forced to choose between providing care on an exclusively private-pay basis to the wealthy, or be forced into the reality of virtually all residents becoming Medicaid-eligible.

Continuing Care Retirement Communities (CCRCs)

CCRCs provide an integrated housing and health care system for seniors. CCRCs typically include independent living, assisted living, and skilled nursing care components on a single campus and under a singe contract. Erickson communities include these three components, plus a wide array of health and supportive services, including physician services, home health care, and extensive resident life programs. Residents of CCRCs experience enhanced quality of life and have significantly better health care outcomes as a result. By keeping seniors out of nursing home care, we can provide better service at a lower price to the government.

In order to gain admission, CCRCs require applicants to disclose their assets and sign a contract that pledges their assets to finance health care needs. CCRC residents pay an entrance fee (which ranges from $100,000 to over $300,000 at Erickson Communities) and monthly fees for the services they receive, including health care, meals, activities, and a variety of other services.

As a result, the CCRC model is only available to middle income and upper income seniors. In Erickson communities and many other CCRCs, the entrance deposit is available to pay for nursing care should a resident spend through other assets. Alternatively, the principal of the entrance deposit is also refundable to the resident if he or she chooses to leave the community or refundable to a designated beneficiary if he or she passes away.

CCRC residents also use dramatically less acute and long term care services than seniors living in the broader community. For example, the typical Erickson resident costs $7,600 per year while the average overall Medicare beneficiary costs $10,000 per year. By encouraging an active lifestyle that focuses on prevention and early engagement, we are able to keep most of our residents out of the nursing home setting altogether.

CCRCs provide tangible value to senior health care and the Medicaid program. First, by providing access to health care and an active social environment, residents of CCRCs are less likely to need nursing home care than the general population. Second, the CCRC contract and large up-front entrance deposit ensure that qualifying individuals privately fund their long term care needs before becoming eligible for Medicaid. This innovative approach can only work if Medicaid is truly a payer of last resort.

Attorneys Employ Loopholes to Inappropriately Qualify Wealthy Seniors for Medicaid

Over the last few years, the business of asset shifting has increased dramatically. In fact, the largest single area of growth within the bar is estate planning. With the aging of the baby boomers, these trends are certain to continue unless the Federal government acts. In the last four years, aggressive attorneys who specialize in asset shifting have targeted CCRCs in two ways to qualify beneficiaries with hundreds of thousands of dollars for costly Medicaid benefits.

Here is the typical argument given. First, the attorneys argue that entrance deposits are excluded assets for Medicaid eligibility purposes. This preserves the significant sums in CCRC entrance deposits for inheritance purposes, while qualifying CCRC residents for Medicaid benefits. CCRC residents with hundreds of thousands of dollars earmarked for their own health care are instead shifting the costs of their long term care to the tax payers. Second, the attorneys argue that contracts that require the disclosure of assets and the pledging of those assets to pay for services are inconsistent with federal policy. Each of these tactics subvert the CCRC contract into an inheritance preservation device.

Absent Congressional intervention, these attorneys will continue to exploit current loopholes to preserve the substantial sums in CCRC entrance deposits for inheritance purposes, while shifting the costs of nursing home care to Medicaid. The following is just a small sample of the creative ways attorneys are trying to use the Medicaid program for the benefit of their middle and higher income clients (and their adult children).

> We had one active member of the bar suggest that we actually raise the price of our entrance deposits and market our community as an effective way to shelter more money for inheritance purposes.
>
> We had a couple move into an Erickson community and disclose over $500,000 in assets. They paid an entrance deposit of over $200,000. Within four months of admission, the husband was declared eligible for Medicaid.
>
> We have had attorneys argue against using entrance deposits to pay for the health care needs of nursing home residents, yet at the same time, use the funds in the entrance deposits to pay their own legal fees.
>
> In one of our Massachusetts communities, there is a couple with over $300,000 reserved in an entrance deposit. The entrance deposit is contractually available to pay for health care. Despite this significant sum, the couple is receiving Medicaid benefits.

Asset Shifting Upheld By Courts:

Absent a clear Congressional declaration of public policy intent, the courts have often looked favorably on the practice of asset shifting to gain Medicaid eligibility. The adult children of CCRC residents have successfully challenged the private pay financing structure for middle income and wealthy seniors. Under interpretations of current law, a CCRC or a state recovery program cannot enforce contracts signed by seniors who disclose assets and pledge those assets to fund their own care.

> In Oak Crest Village vs. Murphy, (379 Md. 229, 841 A.2d 816) Maryland's highest court upheld a ruling that endorsed asset shifting. A couple entered the community disclosing net worth of nearly $500,000 and pledged those assets available to fund their own care. In the same month as signing the contract to pay for their own care, the assets were shifted to an annuity and one of the spouses applied for Medicaid nursing home benefits.

The Erickson experience is limited to CCRCs. However, asset shifting is widespread throughout long term care.

In In Re Keri, (181 N.J. 50, 853 A.2d 909) the New Jersey Supreme Court endorsed the principle of asset shifting. In this case, a nursing home resident's son also served as Power of Attorney (POA). As the POA, the son decided to take all of his mother's assets and shift the costs of his mother's care to the tax payers. Ignoring the cost implications to Medicaid, the Court noted that a "competent, reasonable individual ... would prefer that his property pass to his child rather than serve as a source of payment for Medicaid and nursing home care bills."

The Keri Court models its decision on New York state case law, which permits POAs "to engage in asset shifting even when the guardians themselves may be the recipients of transfers from the wards' assets."

Asset Shifting Places the Inheritance Interests of Adult Children Ahead of Adequate Funding for Health Care for Poor Americans.

(1) In Maryland, the Governor's budget proposed over $70 million in cuts to the Medicaid program. In New Jersey, the Governor's budget proposes a $100 million cut to the nursing home component of the Medicaid program. These cuts may result in reduced services overall, lower quality services to Medicaid recipients, and increased medical standards for eligibility. Prior to cutting services and limiting enrollment for the poor, Federal and state governments should crack down on loopholes that allow significant numbers of wealthy seniors to qualify for benefits.

(2) If providers cannot count on using contracts that rely on disclosed and pledged private financing, it is difficult to see an alternative to relying exclusively on Medicaid as a primary source for all future senior health services. Prohibiting a provider from relying on private financing sources stifles current and future innovative models of housing and health care.

(3) Allowing asset shifting to continue significantly undermines policy aims to encourage private financing of long term care, including long term care insurance and reverse mortgages.

(4) Court opinions on this topic typically uphold the legality of asset shifting relying on analysis that suggests that Congress is well aware of the significant loopholes and has chosen not to act to change the law.

(5) The benefits of asset shifting are only available to citizens sophisticated enough to hire an attorney, who specializes in asset shifting, at great expense.

Specific Recommendations:

Once again, I applaud the committee for examining ways to improve the provision of long term care. I encourage the committee to include the following changes as it develops its Medicaid reform legislation this year.

CCRCs Policy Reform:

- Encourage seniors to privately fund their long-term care needs by clarifying that CCRC contracts that require residents to spend disclosed assets prior to applying for Medicaid are enforceable; and
- Clarify in statute that CCRC entrance deposits that are available to pay for long term care costs must be spent prior to being eligible for public assistance such as Medicaid.

General Medicaid Policy Reform:

- Clarify that the policy intent of Congress is that Medicaid is the payer of last resort.
- Close loopholes that treat income and assets differently-allowing the use of annuities to shelter significant sums of assets;
- Lengthen the 3 year look back period; and
- Increase the penalties for inappropriately gifting assets.

Once again, I deeply appreciate the willingness of the committee to more fully understand the growing problem of asset shifting and its short and long term impacts on the Medicaid program and the provision of long term care in general. In closing, I recommend to you the following Wall Street Journal editorial which does an excellent job of addressing the current situation as well as demonstrating its potential impact on our health care system.

Reprint from Wall Street Journal Editorial

Medicaid for Millionaires

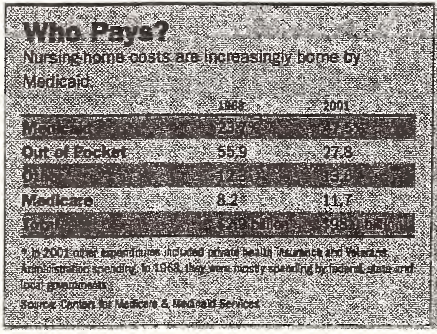
February 24, 2005; Page A14

Medicaid was established in 1965 with the worthy aim of providing medical care for the poor; it was never intended as a middle-class entitlement or as inheritance protection for the children of well-off seniors. Yet the latter is precisely what has happened -- to the point that sheltering assets and income to qualify for Medicaid is now as routine as writing a will.

If you don't believe us, Google "Medicaid estate planning" on the Web and see what pops up. There's a whole "elderlaw" industry out there dedicated to the children of seniors who want to make sure that other taxpayers, not they, pay for nursing-home care via Medicaid should mom or dad ever need it. As one advertiser puts it, "You can qualify for Medicaid while preserving most assets & savings!"

Such "asset-shifting" may be morally questionable, but in most cases it is entirely legal. Anyone can give away most of his assets and three years later become eligible for Medicaid with no questions asked. Or, since a home, business and car of unlimited value are excluded from the calculation of assets, someone who wishes to qualify for Medicaid may shield his money by remodeling his house, investing in the family business, or purchasing expensive cars that he then gives away to family members (the notorious "two Mercedes rule"). Term life insurance -- also of unlimited value -- is excluded as well.

Medicaid "planners" often counsel well-to-do clients to save enough money to pay for a year of care at a private, high-quality nursing home, which under federal law can't kick you out if you then switch over to Medicaid. As Stephen Moses of the Center for Long-Term Care Financing points out, "Poor people don't have key money, so they end up in the least desirable 100%-Medicaid facilities, while the lawyers' clients occupy the scarcer Medicaid beds in nicer nursing homes." About 70% of nursing-home patients are on Medicaid.



Who Pays?

Nursing-home costs are increasingly borne by Medicaid

	1968	2001
Medicaid	23.7%	47.5%
Out of Pocket	55.9	27.8
Other*	12.3	13.0
Medicare	8.2	11.7
Total	$2.9 billion	$98.9 billion

* In 2001 other expenditures included private health insurance and Veterans Administration spending. In 1968, they were mostly spending by federal, state and local governments.

Source: Centers for Medicare & Medicaid Services

Congress has periodically tried to clamp down on abuses but usually ends up making things worse. In 1993 it passed a law requiring states to recover the cost of benefits from the estates of deceased recipients (or from the estates of the spouses they pre-decease). This bombed, as most states make only half-hearted efforts to recover Medicaid costs. In 2002, state Medicaid programs spent $46.5 billion on nursing home care but recovered a measly $350 million from estates.

An excellent way to keep seniors off Medicaid would be to encourage more to buy their own long-term care insurance. The Department of Health and Human Services was experimenting with a "Partnership" program to do just that in the early 1990s, only to be shut down by Congressman Henry Waxman (D., Calif.).

Under the Partnership program, a consumer who purchases, say, $100,000 in long-term care insurance can exempt that sum before drawing down the rest of his assets and, if necessary, going on Medicaid. Not only does this give the senior a guaranteed amount of money to preserve for his heirs, the insurance payouts give him the freedom to purchase the long-term care of his choice. If he wishes to use the money for home care, he can do so.

The four states that had already implemented Partnerships before Mr. Waxman imposed a ban -- New York, Connecticut, Indiana and California -- were permitted to proceed and 13 years later their experience suggests that incentives work. According to Michael O'Grady, an assistant secretary at HHS, 180,000 insurance policies have been sold (a faster rate than in non-Partnership states), 2,000 policyholders have received insurance payments, yet only 86 people have gone on Medicaid.

Long-term Care Partnerships are an even better idea now that baby boomers are approaching retirement and every state is looking for ways to slow the growth in Medicaid spending. As part of its proposed reforms, the Bush Administration wants Congress to lift the Waxman ban. Mr. Waxman's office says he remains skeptical, which is not surprising since he is renowned for using his power to make more Americans dependent on government. Many liberals actually want more of the middle class to get hooked on Medicaid because it helps them build support for higher taxes.

The Administration also wants Congress to update the look-back law, so that the three-year grace period for giving away assets doesn't begin until a senior enters a nursing home or goes on Medicaid. Other measures worth considering include eliminating the home exemption, and requiring seniors who need long-term care to take out reverse mortgages (borrowing against the value of their home) to pay for it.

Ohio is considering a proposal under which the state would claim title to a senior's assets, giving him a zero-interest loan against Medicaid benefits until he is deceased and the assets are used to offset the costs incurred by the state for his care. Seniors who choose cheaper care options would get to keep more assets. This is "the most aggressive effort to control long-term care costs anywhere in the nation," says John Goodman of the National Center for Policy Analysis.

Long-term care accounts for about one-third of federal and state expenditures on Medicaid, to the tune of $100 billion this year. It is the biggest driver of skyrocketing

Medicaid costs that are bankrupting many states and localities. Medicaid was created 40 years ago to care for the needy. The rest of us have an obligation to pay for our own care -- or to protect our wealth with private insurance.

Testimony of Patrick J. O'Connell
Chief, Civil Medicaid Fraud Section
Office of the Attorney General of Texas

Mr. Chairman and members of the Committee:

Good morning. My name is Patrick O'Connell. I am an Assistant Attorney General and Chief of the Civil Medicaid Fraud Section of the Texas Attorney General's Office. Thank you for inviting me to testify this morning. In my remarks, I will describe for you the experience of the Texas Attorney General's office in its efforts to identify and obtain reimbursement from drug companies and other persons and companies that have defrauded the Medicaid system in Texas.

As you know, the Medicaid budget for both the Federal government and the states has increased dramatically over the last ten years. In fiscal year 2005, the combined federal and state spending by the Texas Health and Human Services Commission on Medicaid is estimated to be $12.6 billion. The budget for the payment for prescription drugs by Texas Medicaid for that same time period is $2.6 billion or 20% of the total. The sheer volume of the dollars involved provides a huge enticement for those who would attempt to defraud the program.

You are familiar with the Federal False Claims Act which has provided redress for the United States since the Civil War . Texas adopted its own version of the FCA in 1995 which is limited to recovery for fraud against the Medicaid Program. In 1999, in response to concerns about growing claims of fraud and abuse, then Texas Attorney

General, now your colleague Senator John Cornyn, created a special Civil Medicaid Fraud Section within the AG's office. I have had the privilege of heading up the section since its inception.

When the section was formed, our plan was to aggressively pursue all types of fraud against the Medicaid program. We have investigated and pursued claims against doctors, hospitals and other providers which involved typical claims of false billing, false cost reporting and overbilling; however, the overwhelming majority of our time and efforts have been concentrated on drug manufacturers. Did we target or place special emphasis on drug manufacturers on purpose? No. The fact is that whistle blowers brought us cases which showed significant fraud in amounts which dwarfed the cases against other providers. Because of the limited number of staff and resources we can bring to any one case, we chose to pursue those cases which provided the greatest return to the Medicaid program.

To date, we have sued six drug manufacturers in cases brought to us by Ven-a-Care of the Florida Keys, Inc. State Medicaid programs are required by Federal law to pay pharmacists for prescriptions filled for Medicaid beneficiaries an amount equal to the programs' best estimate of the pharmacists acquisition cost plus a reasonable dispensing fee.

Ven-A-Care brought information to us showing that certain drug manufacturers violated Texas law by intentionally reporting prices to the Texas Medicaid Program that did not bear a reasonable relationship to the prices for their products that were generally and currently available in the market place. Unlike most other states which derive pricing information from third party price reporting services like First Data Bank, Texas requires manufacturers who want their products to be eligible for Medicaid reimbursement to fill out a questionnaire for each drug they wish placed on the Texas Medicaid formulary. For each drug, the manufacturer must report its prices to various classes of trade: e.g., its AWP; its price to wholesaler and/or distributor; its direct price; special price to chain warehouse, etc. A drug company representative is required to sign the form and certify that the information included in it is accurate. Texas law also requires drug companies to update the Medicaid Program with any changes in reported pricing within 15 days of the change.

When Texas relies upon an inflated price report in calculating a provider's estimated acquisition cost ("EAC"), the resulting reimbursement to providers is well above the providers' actual acquisition cost, thus providing pharmacies with windfall profits. This difference between what a pharmacy pays for a drug and what it is reimbursed by Medicaid is referred to in the industry as the "Spread." The information brought to us by Ven-a-Care indicated that certain drug companies have knowingly and purposefully misrepresented their reported prices to Texas in order to enhance or drive up the reimbursement spread for their provider customers.

Under the Texas statute, we have broad powers to compel document production and testimony of potential witnesses. In 1999 and 2000, we used these civil investigative demand powers to require several manufacturers to produce documents. We also took examinations under oath of several industry representatives. Based on the information that we received from Ven-a-Care, as well as the information we received pursuant to the CID process, General Cornyn authorized us to intervene against three of the VAC defendants in September 2000: Warrick Pharmaceuticals, Dey Laboratories, and Roxane Laboratories. The Texas lawsuit was the first state intervention in a qui tam case involving pharmaceutical manufacturer pricing fraud. These three manufacturers competed with one another in the market for certain generic inhalant medicines that are typically prescribed for diseases like asthma. The defendant drug companies are all very ably defended by first rate, nationally prominent counsel. The defendants spared no expense or effort to defend themselves against our allegations. In the almost four years from the State's intervention until the settlement with Warrick in May 2004, the litigants took approximately **120 oral and videotaped depositions**, and exchanged literally hundreds of thousands of pages of written documents. Over this same time period, the State and Relator devoted tens of thousands of man-hours to this litigation, incurring millions of dollars in costs and attorneys' fees.

The evidence we have discovered in the lawsuits as well as in our pre-litigation investigations shows that some manufacturers make conscious, deliberate business decisions to create enhanced spreads and to market the sale of their products based on the spreads. For example, manufacturers engaged in the following activities:

- purposefully reported false and inflated prices to Texas Medicaid - as well as to third party price reporting services - in order to create enhanced spreads;
- deliberately failed to report prices to certain classes of trade in violation of Texas law;
- instructed their sales personnel to market spreads to customers;
- created spread sheets showing pharmacies how much more profit they can make off Medicaid and Medicare when purchasing one product over another;
- tied sales personnel compensation to success in marketing the spread.

We also found that some manufacturers actually kept two sets of computer records with prices: one, with inflated prices that are reported to the price reporting services like First Data Bank, or in Texas' case, directly to the Medicaid Program; and another with real contract prices that are used in every day business transactions with the manufacturer's customers.

In June 2003, we settled our case with Dey for **$18.5 Million.** In this settlement, we recovered more than two times the actual damages to the Medicaid Program, as well as all of our costs and attorneys' fees. In May 2004, the case against Warrick settled for **$27 Million.** Again, Texas recovered more than two times the actual damages to the Medicaid Program, plus our costs and attorneys' fees.

In the two settlements with Dey and Warrick, Texas recovered for the federal and state treasuries a total of **$45.5 Million.** Together with collections in other cases, we have recovered approximately **$63 Million** in the last 5 years.

It is important to remember that these were Texas State settlements only. In addition, our office, working in conjunction with the National Association of Medicaid Fraud Control Units, the Department of Justice and various U.S. Attorneys around the country, has recovered an additional **$58 Million** over the last few years. Again, this figure represents recoveries for damages in Texas only. My office continues to provide assistance to those authorities in other jurisdictions who are pursuing these and other companies. We have developed close and cooperative working relationships with the United States Department of Justice and with other state attorneys general who have instituted similar litigation. So far, California, Kentucky, Florida, Illinois, Massachusetts, Minnesota, Missouri, Connecticut, New York, Ohio, Arkansas, Wisconsin, Nevada, West Virginia and Alabama have followed Texas' lead and sued drug companies for false price reporting. Representatives of these States and the DOJ have visited Texas on many occasions, and we are pleased to share with them the lessons learned in our litigation against Dey and Warrick.

The case against Roxane Laboratories is still pending in Travis County, and we have also intervened against three additional defendants, Abbott Labs, Baxter Healthcare, and B. Braun Medical. The cases against all four of these drug companies are proceeding and we are in the discovery phase, where we are taking depositions and exchanging documents. The Roxane case is scheduled to go to trial next Spring; and the case against Abbott, Baxter and B. Braun will be scheduled for trial later in 2006.

Despite our efforts, some unscrupulous drug manufacturers continue to devise ways to defraud Texas Medicaid, and we are doing everything in our power to bring those companies to justice. Besides pricing fraud, there are a number of other ways in which we believe drug manufacturers are defrauding the Medicaid system. These methods include:

1. Rebate fraud;
2. Nominal pricing fraud; and
3. Off label marketing fraud;

In order to prevent the imposition of price controls by the federal government and to allow the free market system to determine prices while allowing the Medicaid programs to obtain the best price available for drugs, you passed legislation which required drug manufacturers to pay rebates to the State Medicaid programs based upon either a percentage of the Average Manufacturer Price ("AMP") or the difference between the AMP and the manufacturer's "Best Price" as reported to CMS. Some manufacturers have failed to accurately report their AMP and/or their Best Price. When they do so, the Medicaid program does not end up paying the lowest price as the legislation intended. In addition, when calculating Best Price, manufacturers do not have to include sales to entities at "nominal pricing." This provision was designed to allow manufacturers to provide product to charitable entities at basically no cost or little cost without requiring them to use that price to calculate their rebates. However, some manufacturers have illegally used this provision to discount the prices of their drugs to their normal customers without lowering the Best Price.

Another type of fraud which can affect the rebate is illegal bundling. Bundling is a discount offered to a customer for purchases of package of multiple products. When a manufacturer does not properly apply the discount across the array of drugs in the bundle, it can improperly lower its rebate obligations to the states.

Recently the states and DoJ settled a case against Pfizer for off-label marketing of Neurontin. Off-label marketing is the inappropriate representation by a manufacturer of a drug's efficacy for indications that have not been approved by the FDA. Some manufacturers engage in off-label marketing schemes to increase sales and utilization of their products. When that happens, Medicaid pays for inappropriate and ineffective drugs.

New cases are filed with our office virtually every day. We are currently investigating allegations of the kinds of fraud I have just described, or similar fraudulent acts or behaviors in over 100 open cases.

I would also like to bring to your attention a recent case we have filed against Caremark, one of the largest pharmacy benefit managers ("PBMs") in the country.

Federal law makes clear that, when a Medicaid beneficiary is also covered by other insurance, Medicaid should be the payer of last resort. When Medicaid pays for a prescription for a "dual eligible", it can either require the pharmacist to "cost avoid" (meaning that the pharmacist must determine whether other insurance is available) or it can pay the pharmacist and go after the primary insurer for reimbursement. Texas is a "pay and chase" state. Caremark has developed plans for its customers which do not pay for paper claims, do not pay for claims not made at the point of sale, and do not pay for claims not filed within short periods of time. These restrictions are then applied to demands by Medicaid programs for reimbursement which has the effect of negating any ability of the Texas Medicaid program to be paid. We believe that this behavior was not what you intended when you passed the Medicaid legislation. During the course of our discussions with Caremark, we required the production of records which showed all of the individuals who had been covered by Caremark plans. We discovered that, not only had Caremark failed to reimburse Medicaid for those claims which Medicaid knew there was primary Caremark coverage, but there were than ½ million prescriptions paid by Medicaid for individuals covered by these plans for which Medicaid had no prior knowledge and had made no prior claim. The reason for this is that there is NO requirement for Caremark, Medco, Express Scrips (which handle 90% of drug reimbursement in the nation) or any other PBM to report their covered lives to CMS or Medicaid. We believe it is imperative that all PBMs be required to report on a quarterly basis to CMS their covered lives. If this is required and the state Medicaid programs are allowed access to this centralized information, each State will be assured the ability to collect from the primary insurer those funds being missed today.

In closing, I would like to make clear that, while Texas is pleased to have recovered significant sums of money in these *qui tam* cases, litigation is not the most efficient way to run this system. The Texas VDP has been required to spend thousands of man hours responding to discovery requests and preparing for and attending depositions in our litigation. The program could have used our hard earned tax dollars to provide more and better services if VDP personnel were not tied up in litigation caused by manufacturers who game the system.

One way that federal law could be strengthened, to protect against manufacturer pricing fraud, is to expand ASP + 6% payment you created in the Medicare Modernization Act. Such a payment system, while still relying on the truthfulness of drug manufacturers, would allow states like Texas to save significant funds expended to estimate provider acquisition cost.

Our current Texas Attorney General, Greg Abbott, has committed the resources of the agency to our efforts to fight Medicaid fraud in Texas. Through his leadership and vision, we have obtained the funding to increase our staffing to 8 lawyers plus support staff. Even with this additional staffing, we cannot pursue every participant in the system that we find has engaged in this type of activity. We simply do not have the man-power.

For this reason, we are hopeful that Congress will continue to support the efforts of our partners in the Department of Justice. In our opinion, it is also vitally important that Congress maintains the strength and integrity the federal False Claims Act. We would not be able to obtain the successes that we have enjoyed without the participation of relators who have had the courage to come forward.

My time is about up. Thank you for your attention. I am happy to answer any questions.

DHS
oregon department
of human services

Written Testimony of
Paul J. Pickerell
Office of Administrative Services, Financial Recovery
Oregon Department of Human Services

Before the Committee on Finance

United States Senate

Medicaid Fraud, Waste, and Abuse: Threatening the Health Care Safety Net

Chairman Grassley, Senator Baucus, and Members of the committee, my name is Paul Pickerell, Financial Recovery Manager, Oregon Department of Human Services (DHS). Thank you for the opportunity to provide testimony on Oregon's estate recovery program.

1. Estate Recovery in Oregon.

   Oregon enacted legislation in 1949 authorizing the state to recover the cost of state-provided cash assistance to the elderly. In 1975 legislation was enacted authorizing recovery of the cost of medical assistance provided to persons 65 and older.

   The mission of the Estate Administration Unit (EAU) is to recover from the estates of Medicaid recipients the cost of cash and medical benefits provided. Our program aggressively corrects disqualifying transfers of assets, and is active in the preservation of assets so they may be available for the current cost of care as well as the estate. Our goal is to increase estate recoveries while protecting the personal and property rights of the people we serve.

   When the Oregon DHS has a claim, it is a priority claim against the property, or any interest therein, belonging to the estate of the deceased person. If there is a surviving spouse, no recovery occurs until the death of the surviving spouse. DHS will have a claim against the estate of the surviving spouse for aid paid to the deceased spouse, but only to the extent that the surviving spouse received property or other assets from the deceased client at

   the time of death through probate or through operation of law. In addition, DHS will also have a claim against the estate of the surviving spouse for any aid paid to the surviving spouse.

   No claim is asserted when there is a surviving child of the client who is under age 21, or blind, or permanently and totally disabled.

2. In Federal Fiscal Year 2004, the EAU recovered $18,965,250. During that time period the Medicaid expenditures in recoverable programs totaled $1,260,418,554. Average number of cases handled: nearly 7,700. It is estimated that over 40% of the deceased Medicaid recipients have either exemptions that waive or defer recovery from their estate.

3. Oregon's estate recovery program has been successful, within the existing legal parameters, because it has developed a number of business practices that have successfully addressed the problems inherent in pursuing estate recovery. The relative success of our program is predicated, first and foremost, on the skills of the employees that implement the program. They are dedicated staff who believe in their job. They represent a diverse mix of experience, in background and education, with legal, paralegal, title experience, Medicaid eligibility experience, collections experience, and experience delivering services directly to clients. This varied staff background compliments and balances our program and ensures that there is sensitivity to families while at the same time we recover resources that can be utilized to help other low-income senior and disabled clients. Some of the practices the Oregon utilizes or recommends are:

    a. Highly recommend that states utilize the "expanded definition of estate", contained in Section 1917(b)(4)(B) of the Social Security Act, which includes language that allows for recovery of assets conveyed through joint tenancy, tenancy in common, survivorship, life estate, living trust or other similar arrangement (e.g., annuity). Using this expanded definition allows for the pursuit of assets that many existing state probate definitions would preclude.

    b. Implementation of a statewide electronic notification process that alerts the estate recovery unit of the Medicaid client's death. In the estate recovery process, time is of the essence. The sooner the state can take actions to initiate recovery, the greater likelihood that assets will be intact. The electronic notification should also, ideally, allow for a review of the electronic narrative of the case history, because such a review can reveal critical facts or information on estate assets sometimes not disclosed on the "official" notification document.

    c. Regular on-site training on the estate recovery process at local eligibility/service units around the state, by estate recovery staff who are knowledgeable about the complexity and intricacies of probate, title, and property law. There is no adequate substitute for hands-on training in the field, to explain the process and answer questions. Support of the estate recovery program in the field by case managers and eligibility specialists is critical. They provide the information upon which all subsequent estate recovery activities are based.

    d. Regular involvement by estate recovery staff in the training component of new field workers who will be implementing the Medicaid program. Training and orienting new staff to the importance of the estate recovery process provides accuracy, consistency and uniformity to the information disseminated to clients and family members.

e. It is critical that management and/or professional representatives of the estate recovery unit work closely with state Medicaid eligibility policy staff. Without a good working relationship, estate recovery activities may inadvertently be harmed if eligibility policy staff are not aware of estate recovery issues.

f. Utilization of a probate specialist within the recovery unit whose primary responsibility is matching the names and social security numbers of all new probates filed in the county courts with the data base of deceased Medicaid recipients/surviving spouses, to ensure that the state is afforded an opportunity to submit its claim in a timely manner. This position can be extremely cost effective relative to the number of claims identified and the revenue subsequently generated.

g. Development and utilization of a standardized series of letters that are legally defensible and address the most common situations that are encountered by the estate recovery unit. This provides uniformity in correspondence and reflects the state's commitment to pursue recovery.

h. Secure statutory authority for the state Medicaid agency to be a "priority creditor" under state probate law. There is no reason why general creditors should be in the same position as the state when the recovery of public monies is involved.

i. Maintain regular contact with your CMS state representative to discuss estate recovery issues. Formally submit written requests to CMS for clarification of Medicaid policy in instances where there is ambiguity.

j. Maintain regular contact with other estate recovery managers/staff in neighboring states, to identify new estate recovery "avoidance" strategies, trends, and to discuss possible remedial approaches. On topics of estate recovery that apply regionally or nationally, develop regional approaches to securing change by working with your state counterparts in drafting "regional position papers" on estate recovery issues that require CMS evaluation, research, and response.

k. Introduce legislation to secure statutory authority to receive, as the state Medicaid agency, notification of all probate notices filed within the state. Such notification will allow the state to file a claim in probates where the death of a former Medicaid client (someone who died off of assistance) would otherwise have been unknown to estate recovery staff, and may also identify property that the estate recovery unit was unaware that the deceased client had an interest in.

l. Secure statutory authority to place liens on real property of deceased Medicaid recipients. Although they can be somewhat cumbersome administratively, there can be no doubt that such liens insure that the estate interest in the real property, specific to the public assistance provided, will be secured.

m. Information, information, information. Develop an estate recovery brochure to be included with all Medicaid applications and as handout available at all local Medicaid offices, that clearly and concisely outlines the estate recovery process. Ideally, the brochure should list a 1-800 (toll free) number that individuals may call to receive additional information on the estate recovery program. This brochure can make a significant impact in reducing client and family apprehension if it presents information on estate recovery in a forthright and open manner. No Medicaid client should ever be surprised that there will be an effort, within specific parameters, to recover public assistance that has been provided to them.

n. Secure subpoena authority to directly access financial records of the Medicaid decedent. This can sometimes identify fraud or possible financial exploitation of vulnerable seniors.

o. Secure authority to file a “Request for Notice” with the county clerk to notify the state whenever client real property is transferred or encumbered.

p. Utilization of an asset change specialist position. Researches electronic narratives when assets have dropped off during re-determinations of eligibility. Assures proper accounting of assets.

q. Secure authority to nominate a personal representative to handle the estate. Allows state to utilize an independent third party to probate estate assets when a family is unwilling or unable to probate estate themselves.

r. Pursue existing title and real property (assessor) resources to research the title history and valuation of real property in which the deceased Medicaid client may have held an interest.

s. Train and reinforce among estate recovery staff the importance of working with family members to resolve issues involving the Medicaid claim, prior to pursuing legal options against the estate.

3. Recommendations on changes to Federal law that would assist in the integrity of the Medicaid program.

Interspousal Transfers – An interspousal transfer is the transfer of assets from the spouse, which is receiving or will receive Medicaid, to the spouse that will not receive Medicaid. Medicaid recipients can transfer an unlimited amount of assets to a spouse. 42 USC 1396p(c)(2)(A)(i).

A person with substantial assets has a number of interspousal transfer techniques that can be used to become eligible for Medicaid. These are some of the many techniques that are commonly known as "artificial impoverishment." The second phase of "artificial impoverishment" is avoidance of estate recovery. In short, Medicaid can be used as a technique to protect inheritances for Medicaid recipients' children.

Estate recovery consists of sending a claim to the estate of a deceased Medicaid recipient's estate. 42 USC 1396p(b)(1); Oregon Revised Statute (ORS) 414.105. If the Medicaid recipient is survived by a spouse, no claim is submitted to the estate of the deceased Medicaid recipient. 42 USC 1396p(b)(2); ORS 414.105. When the spouse passes away estate recovery is permitted. 42 USC 1396p(b)(2); ORS 414.105.

However, when the surviving spouse passes away, the claim must be submitted to the surviving spouse's estate. ORS 414.105. The only assets in the surviving spouse's estate available to satisfy the claim are assets that passed from the Medicaid recipient at death to the surviving spouse. ORS 414.105. Therefore, assets that went from the Medicaid recipient during his lifetime, such as interspousal transfers, are not available in the surviving spouse's estate to pay an estate recovery claim. See ORS 414.105.

The three most common interspousal transfers that avoid estate recovery are:

- Court Orders – Federal law allows a Medicaid recipient to transfer an unlimited amount of assets to a spouse, and to have those assets be excluded from determining the Medicaid recipient's eligibility, if the transfer is pursuant to a court order. 42 USC 1396r-5(f)(2)(A)(iv); 42 USC 1396-5(f)(3). Oregon law allows for these types of court orders for married couples. ORS 109.110. It is not unusual for married couples in Oregon to shelter up to $180,000 in assets, not including the family home and automobile. Since these transfers occurred during the lifetime of the Medicaid recipient these assets will not be available to pay an estate recovery claim when the recipient's spouse dies. ORS 414.105.

- Home – The home of a Medicaid recipient is not counted in determining the eligibility of the recipient. In Oregon, frequently, the Medicaid recipient will transfer his or her interest in the home to his or her spouse. Once again since the transfer occurred during the Medicaid recipient's lifetime the equity in the home will not be available to pay an estate recovery claim when the recipient's spouse dies. ORS 414.105.

- Annuities – Certain types of annuities owned by the Medicaid recipient's spouse are not countable in determining the Medicaid recipient's eligibility. See 42 USC 1396p(d)(6); CMS State Medicaid Manual Part 3, Section 3258.9B. Frequently, the Medicaid recipient will transfer most or all of his or her assets to his or her spouse. The spouse then uses those assets to purchase an annuity that is not countable in determining the Medicaid recipient's eligibility. Again, since the asset transfer was during the lifetime of the Medicaid recipient, the annuity is not available to pay an estate recovery claim when the spouse dies. ORS 414.105. Oregon has seen cases where upwards of $500,000 in assets have been sheltered by this method.

Eliminate restriction that prevents recovery of assistance provided before the age of 55 for non-institutionalized individuals. 42 USC 1396p(b)(1)(B).

Currently estate recovery, in most instances, is restricted to assistance received after the age of 55.

Eliminate restriction from recovery of assistance from a Medicaid recipient's estate when a surviving disabled child is disinherited. 42 USC 1396(b)(2)(A).

When a Medicaid recipient is survived by a permanently and totally disabled child there will be no estate recovery claim. This is true even when the disabled child receives no benefit from the estate of the deceased recipient, and the entire estate passes to the recipient's "healthy" children or anybody else, such as a neighbor.

To summarize, estate recovery and Medicaid eligibility are two sides of the same coin. Whatever criteria is allowable in establishing eligibility under Medicaid has a direct and measurable consequence on the availability of resources upon which to present a claim when the Medicaid recipient passes away. The two are inextricably linked. Assets that may be sheltered, transferred, or in some other manner removed from consideration, mean that at the present time they are not subject to recovery when the Medicaid recipient passes away. Therefore, what is exempted from resource consideration, the Medicaid eligibility "look-back" period for determining whether there has been a disqualifying transfer, when the disqualification begins, allowable transfers of real and personal property, etc., all impact estate recovery.

Thank you for the opportunity to testify. I'd be happy to take your questions.

Testimony of Marjorie E. Powell
Senior Assistant General Counsel
Pharmaceutical Research Manufacturers of America
Senate Finance Committee Hearing: *Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net*
June 29, 2005

Mr. Chairman, Senator Baucus, and Members of the Committee:

Thank you for the invitation to participate in today's hearing on *Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net.* My name is Marjorie Powell and I am the Senior Assistant General Counsel of the Pharmaceutical Research and Manufacturers of America (PhRMA). PhRMA represents the country's leading research-based pharmaceutical and biotechnology companies. Our members are leading the research into developing medicines that allow patients to lead longer, healthier, and more productive lives.

PhRMA members have developed numerous medicines that have dramatically improved care for Medicaid patients, such as medicines that treat diabetes, mental illnesses, asthma, HIV, and immunizations for childhood illnesses. Prescription medicines are a small but critical part of Medicaid. While we note that, based on our analysis of publicly available data, the percentage of Medicaid expenditures spent on brand name prescription drugs is less than seven percent, and shrinking as a result of the transition of dual eligibles to Medicare, medicines invented by PhRMA members often are a central component of disease management programs used by Medicaid programs to deliver better care more efficiently.

Mr. Chairman, on behalf of PhRMA and our member companies, I would like to recognize the significant contributions that you and your Committee have made, and will continue to make, to the entire health care system. Your Committee's work on behalf of seniors and disabled Americans in enacting a Medicare prescription drug benefit will make a profound difference in the access and affordability of medicines for millions of Americans. Additionally, your oversight and attention to the integrity of the Medicaid program, the subject of yesterday's and today's hearings, will lead to a better understanding of the Medicaid program and its operations. Medicaid is a vital safety net to millions of low income families and children, providing quality health care services to many who would otherwise be uninsured and without needed care.

PhRMA and its member companies fully support your Committee's efforts to improve compliance and prevent fraud and abuse in the Medicaid system.

In your June 23, 2005 letter inviting PhRMA to provide its views on Medicaid fraud and abuse, you specifically requested that we comment on both the Draft OIG Compliance Program Guidance for Pharmaceutical Manufacturers (the "Draft Guidance"), published by the Office of Inspector General on October 3, 2002, and the final version of this document (the "Final Guidance") published by the OIG on May 5, 2003. PhRMA's previous comments on the Draft Guidance and my testimony here today are limited to policy issues, such as the general need for clear guidance for manufacturers to follow. As you know, the antitrust laws prohibit competitors from discussing pricing practices or other business strategies. As an association of competitors, PhRMA cannot, and under the antitrust laws does not, have knowledge of, or involve itself in, the business practices of its members. Specifically, PhRMA does not have any information, and cannot comment, on the pricing data submitted by individual manufacturers, or the assumptions manufacturers might make about the Average Manufacturer Price (AMP) or best price calculations.

Trade associations like PhRMA can develop and adopt general policies or guidance on issues of importance to the public interest. For example, the OIG Draft Guidance and Final Guidance both reference the PhRMA Code on Interactions with Healthcare Professionals (the "PhRMA Code"). In 2002, PhRMA adopted the current version of the Code in response to concerns that had been raised about manufacturers' relationships with health care professionals. Through a series of principles and questions and answers, the Code provides guidance to companies about practices including information presentations by pharmaceutical companies, third party educational or professional meetings, physician consulting arrangements and scholarships or educational grants.

With respect to the OIG's Compliance Program Draft Guidance, PhRMA submitted written comments on the Draft Guidance to the OIG on December 2, 2002. In those comments, we applauded the OIG's efforts to provide clear guidance to pharmaceutical manufacturers. We did suggest that the OIG further clarify or reconsider certain aspects of the Draft Guidance. For example, PhRMA concurred with the OIG's call for integrity in the data reported by companies in connection with the Medicaid rebate program. While PhRMA does not have any information on manufacturers' pricing data or the assumptions manufacturers may make about prices such as in AMP or Best Price calculations, we did point out in our comments that our members' ability to provide accurate data depended on "their having a clear understanding of what data is required to be reported and, in the case of prices such as 'Average Manufacturer Price' and 'Best Price,' a clear understanding of how prices are to be calculated under the applicable law."[1] In addition, we noted in our comments that CMS had not promulgated regulations defining these aspects of the Medicaid rebate program, and that in the absence of clear guidance, manufacturers would have "to make good faith efforts to define these terms on their own in a manner consistent with the Medicaid Rebate statute and the Medicaid Rebate Agreement."[2]

A recent Government Accounting Office (GAO) report noted that regulations in this area have not yet been promulgated. In its February 2005 report, *Medicaid Drug Rebate Program: Inadequate Oversight Raises Concerns about Rebates Paid to States*, the GAO recommended that CMS issue clear guidance on manufacturer price determination methods and the definitions of best price and AMP, and update such guidance as additional issues arise." [3]

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[1] PhRMA Comments on Draft Guidance, Page 3.

[2] *Id.*.

You also requested we comment on the Final Guidance. PhRMA has not developed any policy or position with respect to the Final Guidance issued by the OIG. Generally, our association does not develop policy on final guidances issued by an agency. It should be noted, however, that a number of PhRMA's suggestions were incorporated into the Final Guidance. For example, the Final Guidance viewed PhRMA's Code on Interactions with Healthcare Professionals as not just a "minimum" standard, as suggested in the Draft Guidance, but as "substantially reduc[ing] risk of fraud and abuse and help[ing] demonstrate a good faith effort to comply with the applicable federal health care program requirements." [4]

The Committee's letter also asked PhRMA to comment today on whether the Final Guidance has been "fair and effective" in reducing fraud, waste and abuse in the Medicaid program. Unfortunately, PhRMA is not in a position to respond to the Committee's request. Under the antitrust laws, our member companies participate independently in federal programs such as Medicaid, and it is up to each individual company to develop and implement its own procedures to comply with the laws and regulations governing its participation in those programs. PhRMA has no role in monitoring or operating company compliance programs.

Again, PhRMA appreciates the opportunity to appear before the Committee today and to hear from the others on the panel regarding the Medicaid program. If the Committee develops proposals for reform as a result of this hearing or its other oversight activities, PhRMA would welcome the opportunity to comment on those reforms from a policy perspective. We appreciate the importance of the Committee's oversight responsibilities and fully support the Committee's efforts to ensure that the Medicaid program operates efficiently and with the utmost integrity.

Mr. Chairman, that concludes my prepared statement. I would be pleased to respond to any questions.

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[3] GAO Report, *Medicaid Drug Rebate Program: Inadequate Oversight Raises Concerns about Rebates Paid to States* (February 2005) at 5.

[4] 68 Fed. Reg 23731 at 23737.

Statement of Ms. Ruth C. Pundt,
Resident at Oak Crest Village an Erickson Retirement Community

Testimony Before the U.S. Senate Committee on Finance

Medicaid Waste, Fraud, and Abuse: Threatening the Health Care Safety Net

June 29, 2005

Residents' Contractual Obligations to the Erickson Community

I understand Congress has decided to take up the issue of whether or not to take up the issue of whether they will once and for all close the loophole that has allowed Continuing Care Retirement Communities (CCRC) residents to access Medicaid without first spending down their entrance deposits.

The residents at Oak Crest Village, an Erickson CCRC in Parkville, MD, signed a contract to do this, and I intend to fulfill it. Other residents should be required to fulfill their contracts also. As a taxpayer, I believe people with assets should not be able to use loopholes to preserve their assets and shift the burden of paying for their care to others.

America is certainly feeling the budget crunch right now and the consequences could be severe. With federal dollars dwindling, there is pressure to cut Medicaid budgets and other critical programs, actions that could devastate our most vulnerable citizens, particularly the poor and seniors.

Effects of Medicaid Asset Transfers and Spend Down Requirements on Erickson Residents

If the Federal Government allows people who have hundreds of thousands of dollars in CCRC entrance deposits to access Medicaid, it will hurt Oak Crest Village and take money away from the truly needy of our Country and the State of Maryland.

I moved to Oak Crest because of the outstanding quality of care. Allowing undeserving residents to access Medicaid will adversely impact the quality of care; and Medicaid should not be used to preserve inheritances at the cost of providing high quality care to seniors.

Results of Resident Survey Regarding Medicaid Spend Down

A survey of the residents of Oak Crest Village indicated that the residents overwhelmingly supported (97%) the closing of this Medicaid loophole. As a representative of the vast majority of residents at Oak Crest Village, I ask that you close the Medicaid loophole.

Medicaid: Financial Mechanisms To Shift Costs to the Federal Government

Testimony of:
George M. Reeb, Assistant Inspector General
for the Centers for Medicare & Medicaid Services Audits

Hearing Before:
Senate Committee on Finance
Charles E. Grassley, Chairman

June 28, 2005

Office of Inspector General
U.S. Department of Health and Human Services
Daniel R. Levinson, Inspector General

Testimony of:
George M. Reeb
Assistant Inspector General
for the Centers for Medicare & Medicaid Audits
Office of Inspector General, U.S. Department of Health and Human Services

Good morning Mr. Chairman and Members of the Committee. I am here today to discuss States' use of financing mechanisms to shift the cost of Medicaid to the Federal Government, contrary to statutory Federal and State sharing formulas. In particular, I will discuss how States use their intergovernmental transfer (IGT) authority with regard to certain enhanced payments and the negative implications such transfers may have for the quality of care for Medicaid beneficiaries residing in local public nursing facilities. I will describe how States divert funds away from their original purpose once the Federal share is received, leaving poorly performing public nursing facilities under-funded. Then, referencing previous audits, I will summarize some problems we uncovered over the years with respect to tax and donation programs and disproportionate share hospital payments. Finally, I will discuss some concerns emerging from our recent work in other Medicaid benefit areas and outline some accountability issues and basic principles to be followed in ensuring the financial integrity of the program.

We have found that current policies and practices severely limit the ability of Congress, the Department of Health and Human Services, and State and local governments to manage, account for, and assess the benefits of Medicaid dollars. Some financing mechanisms are designed solely to maximize Federal reimbursements to States, contrary to Federal and State cost-sharing principles, and serve to disguise the source and final use of both Federal and State funds.

THE MEDICAID FEDERAL/STATE PARTNERSHIP

Since the inception of the Medicaid program, the Federal Government and the States have shared in the cost of the program. Each State Medicaid program is administered by the State in accordance with a State plan approved by the Centers for Medicare & Medicaid Services (CMS). While the States have considerable flexibility in designing their State plans and operating their Medicaid programs, they must comply with broad Federal requirements. The Federal Government pays its share of medical assistance expenditures to the States according to a defined formula, which yields the Federal medical assistance percentage (FMAP). The FMAP can range from 50 percent to 83 percent, depending on each State's relative per capita income. My testimony deals with practices that circumvent these Federal/State matching requirements and cause the Federal Government to pay disproportionately more, without a corresponding benefit to the intended beneficiaries.

ENHANCED PAYMENTS UNDER UPPER PAYMENT LIMIT RULES

Intergovernmental transfers are transfers of non-federal public funds between State and/or local public Medicaid providers and the State Medicaid agency. This is the most common method we have noted by which States divert funds from an intended purpose after drawing down the Federal share of the benefit.

States' use of IGTs to divert funds has the following consequences: a State's share of its Medicaid program inappropriately declines; Federal taxpayers pay more than their statutory share; and the increased Federal Medicaid funding derived from these financing mechanisms becomes comingled in general revenue accounts, where it can be used for purposes unrelated to Medicaid, including as the State's match to draw down more Federal dollars for Medicaid and other federally matched grant programs.

I would like to point out that there is virtually no need for a State to transfer funds to be used for another Medicaid purpose because States can simply claim Federal funding for any valid Medicaid expenditure. States have the option of managing their Medicaid transactions in ways that are straightforward and auditable. Generally, accountability is lost at the point that Medicaid funds are transferred into general revenue accounts, thereby placing the funds at risk of misuse.

The most conspicuous use of the IGT mechanism in recent years has centered on enhanced payments available under upper payment limit (UPL) rules. The UPL is an estimate of the maximum amount that would be paid to a category of Medicaid providers (usually hospitals and nursing homes) under Medicare payment principles. The difference between the State's reimbursement rate and the UPL is called an enhanced payment. Generally, State payments that exceed UPLs do not qualify for Federal matching funds. In short, the States' use of IGTs as part of the UPL enhanced payment program has been primarily a financing mechanism designed to maximize the Federal share of Medicaid while effectively avoiding the Federal/State matching requirements.

Medicaid regulations allow State Medicaid agencies to pay different rates to the same class of providers as long as the payments, in aggregate, do not exceed what Medicare would pay for the services. Before new regulations took effect on March 13, 2001, State Medicaid agencies were able to calculate the total enhanced payment amount (the difference between the regular Medicaid payment and the Medicare payment amount for a similar service) on the basis of the aggregate of all private, State-operated, and city- or county-operated facilities. The entire amount could then be distributed to only city- and county-owned facilities. The State could even direct the entire amount to only one such facility if it chose to do so. The results of OIG audits demonstrated that billions of dollars were at risk and would continue to be at risk in the future unless substantive changes were made in the program.

In accordance with our early findings and with the Benefits Improvement and Protection Act of 2000, CMS issued a final rule in 2001, which modified the UPL regulations. The regulatory action created three aggregate upper payment limits—one each for private, State, and non-State government-operated facilities. The creation of a separate aggregate payment limit for non-State government-owned facilities effectively reduces the amount of funds that States can gain by requiring public providers to return Medicaid payments through IGTs. The new regulations are being phased in gradually and will become fully effective on October 1, 2008.

When fully implemented, these changes will dramatically limit this State manipulation of the Medicaid program. However, the changes will not entirely eliminate this problem because the regulation still does not require that the enhanced funds be retained by the targeted facilities to provide covered services to Medicaid beneficiaries. Thus, States continue to divert enhanced payments to other purposes.

STATES' USE OF IGTS: EFFECT ON NURSING FACILITIES

Some of our recent audits have explored States' use of IGTs in which some or all of the Medicaid funds that were directed to local public nursing facilities as enhanced payments made under UPL rules were returned to the States instead of being retained at the facilities for the care of patients. The Medicaid funding for such facilities is composed of per diem payments and enhanced payments. When the State's per diem rate is less than the UPL, some States provide enhanced payments to make up all or a portion of the difference.

In the sections that follow, I will describe the results of audits covering various 3-year periods ending in 2001 or 2002. Although the audit periods in some cases included enhanced payments made both before and after the new regulations, the new rules continue to allow States to require providers to return their Medicaid enhanced funds to the State. The nursing facilities were selected for review because State survey and certification reviewers had identified them as having serious deficiencies in patient care. Our objectives were to ascertain whether Medicaid payments to the nursing facilities were adequate to cover their operating costs and whether a link could be drawn between the quality of care of patients and the amount of Medicaid funding received.

In every case, we found that the gross Medicaid per diem and enhanced payments were sufficient to cover operating costs, but the net payments were not. The nursing facilities were all required to return substantial portions of their enhanced payments to the States to be used for other purposes. As a result, the facilities were under funded. We believe this under funding had a negative impact on quality of care. In all four reports, we recommended that the State allow the facility administrators to retain sufficient funding to cover the costs of providing an adequate level of care to its residents.

Generally, once the payments that had been directed to these facilities for patient care were returned to the States, the States were able to use the funds for any purpose, including to draw down new Federal matching funds for Medicaid or other Federal programs.

State of New York: Albany County Nursing Home[1]

The Medicaid combined per diem and enhanced payments made to Albany County Nursing Home in New York for our 3-year audit period were more than adequate to cover its operating costs. However, after the nursing home returned 90 percent of its enhanced funds to the county and State, the net Medicaid payment retained by the facility was $22 million less than the facility's total Medicaid operating costs for the period.

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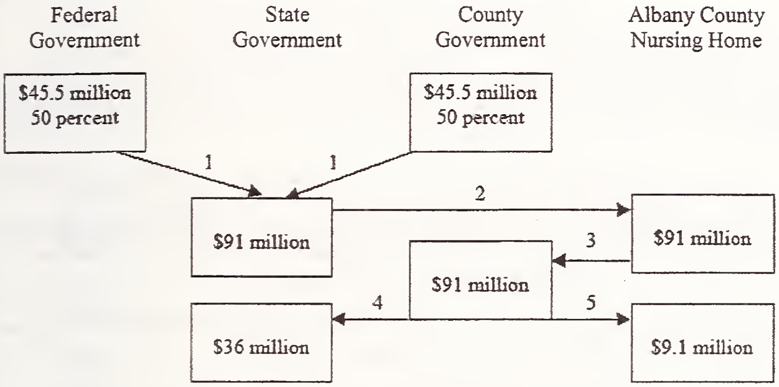
[1] Report A-02-02-01020

This diversion of funds took place despite the fact that the nursing home had received an immediate jeopardy rating from the State Department of Health. An immediate jeopardy rating is the most unfavorable rating that can be issued. The net Medicaid funding fell short of operating costs, and the nursing home did not fill all of its nursing positions. This condition may have affected the quality of care provided to its residents. During our audit period, the nursing home was significantly understaffed compared to the minimum number of positions specified in its budget.

Of the $132 million total payments made to the facility during the period we reviewed, $91 million was from UPL enhanced payments. In New York, the State's agreement with the counties only allowed the counties' nursing homes to retain 10 percent of the UPL enhanced payments that were designated for them. After a trail of transactions, the nursing home retained only $9.1 million of its $91 million in enhanced payments, as illustrated in the following chart:

Flow of Medicaid Funds to/from Albany County Nursing Home

Amounts shown are rounded.



1. Drawdowns by State from Federal Government and county to holding account.
2. State payment to county nursing home operating bank account.
3. County transfer from nursing home operating account to county general fund.
4. State withdrawal from county general fund.
5. Amount designated through county budget for nursing home

Note: The chart represents the totals of funds that were contributed, drawn down, and moved over a period of 3 years.

The $9.1 million in enhanced payments, combined with the total per diem payments of $41 million totaled only about $50 million, which was about $22 million less than the facility's total operating costs of about $72 million for the period reviewed.

The county and State divided the remaining $82 million (90 percent of the enhanced payment amount) between them. The State received $36.4 million, which fully reimbursed the State for its per diem contribution of $16 million and provided a surplus of $20 million that the State could use for any purpose. The county was reimbursed 100 percent for its upper payment limit contribution. The Federal Government, in effect, provided almost all of the nursing home's Medicaid funding, contrary to the principle that Medicaid is supposed to be a shared responsibility of the Federal and State Governments.

State of Washington: Newport Community Hospital, Long Term Care Unit[2]

Total Medicaid payments made to the Newport Community Hospital's long term care unit (nursing facility) during the audit period were adequate to cover its operating costs. However, after using IGTs to divert almost all of the enhanced payment funds to other purposes, the Medicaid amount that the State allowed Newport to retain was $290,000 less than Newport's total Medicaid operating costs. During the same period, the nursing home was understaffed, which may have affected the quality of care provided to its residents. Newport officials believed that they could improve quality of care if they had more funds to hire additional staff, provide more training, improve the facility, and purchase safety equipment.

In addition to the State's requiring Newport to return about 94 percent of its enhanced funding to the State, the State directed Newport to pay about 3 percent of its enhanced funding to other health organizations as well. In effect, the Federal Government provided almost all of the nursing home's Medicaid funding, contrary to Federal/State cost-sharing principles.

State of Tennessee: Nashville Metropolitan Bordeaux Hospital, Long Term Care Unit[3]

We found that the Medicaid payments made to Bordeaux Hospital's long term care unit were adequate to cover Medicaid-related costs, but net payments after IGTs were $22.8 million less than the facility's total Medicaid operating costs for the audit period.

In addition to the shortfall, Bordeaux did not retain enough Medicaid funding to fill all of its nursing positions, which may have affected the quality of care provided to its residents.

During the audit period, Bordeaux's Medicaid operating costs were about $62.5 million. During the same period, initial Medicaid payments to the facility totaled $139.8 million. However, the State and the county required Bordeaux to return about 96 percent of its enhanced payments to the State. We were concerned that the Federal Government effectively provided all of Bordeaux's Medicaid funding, contrary to Federal/State cost-sharing principles. The long term care facility was ultimately under funded, and the transferred funds were available to be used for other purposes.

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[2] Report A-10-04-00001.

[3] Report A-04-03-03023.

State of New York: A. Holly Patterson Extended Care Facility[4]

OIG found that the total Medicaid payments to A. Holly Patterson Extended Care Facility were adequate to cover Medicaid-related costs for the audit period, but net payments after IGTs were $25 million less than Patterson's total Medicaid operating costs. Patterson was also understaffed during the audit period, which may have affected the quality of care provided to its residents. Patterson officials believed that they could improve quality of care if they had more funds. Patterson's Medicaid operating costs for the period were about $190 million. During the same period, Medicaid's initial payments to Patterson totaled $348 million in per diem and enhanced payments. The State and county required Patterson to return about 90 percent of its enhanced payments. As with the other audits, OIG concluded that the Federal Government, in effect, provided almost all of the facility's Medicaid funding, contrary to the Federal/State cost-sharing principle, and the facility, which had been identified by the State as having problems with patient care, was under funded. The amount that was returned to the State and county was merged into general revenues and could no longer be tracked.

RECOMMENDATIONS TO IMPROVE ENHANCED PAYMENTS UNDER UPL RULES

Some recommendations from our audits involving enhanced payments made under UPL rules have not yet been implemented. Following are recommendations that, in combination, we believe would curb the inappropriate transactions that inflate the Federal share.

- Use facility-specific limits to cap the amount of enhanced payments that could be sent to any one facility. These limits should be based on the cost of providing services in that facility by using the facility's actual cost reports.

- Require States to allow public providers to retain their enhanced payments to provide health care services to Medicaid beneficiaries.

- Declare any Medicaid enhanced payments that are returned to the State by public providers to be refunds, with the Federal share of the refund returned to the Federal Government.

- States should calculate per diem rates that more closely reflect operating costs. In the States we reviewed, per diem rates were not sufficient to cover costs.

- Perform annual audits of the States' enhanced payment calculations to ensure compliance with the UPL rules. We are finding incorrect calculations in some States.

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[4] Report A-02-03-01004.

- Shorten the transition periods included in the final upper payment limit regulation since, currently, there are no formal controls to ensure that these added funds are actually used for their purported Medicaid purpose.

OTHER USES OF INTERGOVERNMENTAL TRANSFERS TO INCREASE THE FEDERAL SHARE OF MEDICAID

The State manipulations of the Medicaid UPL enhanced payments are but a continuation of creative financing mechanisms that States began to use extensively starting over 15 years ago. I would like to mention the provider tax and donation programs, disproportionate share hospital payments, and some new areas where similar financing schemes are emerging.

Provider Tax and Donation Programs

Several years ago, States used provider tax and donation programs to increase Federal Medicaid matching funds while at the same time reducing the use of State resources in the Medicaid program. Subsequent congressional and regulatory action helped curtail the earlier problems with provider taxes and donations to a great extent. The taxation matter has, however, continued to be of concern as efforts are made to ensure they are properly implemented. At the request of CMS, our office has begun a new review of the Medicaid provider tax programs that are in use today.

In the earlier tax and donation programs, States would either arrange for providers to donate funds to the Medicaid program or certain provider groups would be levied special taxes. States were allowed by Federal regulations to use these funding sources as the State share of Medicaid expenditures. These collected funds were then repaid to the providers by increasing the total Medicaid reimbursement. As the reimbursements were raised, the providers recouped their donations or taxes, and the State could then use the Federal matching funds for whatever purpose it decided. The Omnibus Budget Reconciliation Act of 1990 affirmed that States were permitted to use provider tax revenues as their share of Medicaid expenditures.

In 1990, the then Health Care Financing Administration (HCFA) asked our office to audit the taxation and donation programs because of HCFA's concern that the use of such taxes and donations had the potential to significantly alter the real rate of the Federal share of Medicaid expenditures. We issued three reports over the next year describing the serious negative impact of these practices. We reported that the potential increase in the Federal share was inestimable and was limited only by the collective ability of institutional providers to participate in the programs. We urged HCFA to propose legislation to close the loopholes. In a 1991 Management Advisory Report to HCFA, we stated: "Provider tax and donation programs are generally not about increasing services to Medicaid recipients; nor are they about improving the quality of care provided to these recipients. They are, in our opinion, carefully crafted financing techniques that allow States to reduce their share of Medicaid costs and force the Federal Government to pay significantly more." We further stated: "Provider programs differ in some respects, but the Federal Government always loses, and States always profit."

Disproportionate Share Hospital Payments

Another financial mechanism that can be the source of both benefit and abuse is known as the Medicaid disproportionate share hospital program. Under this program, payments are made to financially assist hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients. These payments are important because public "safety net" hospitals face special circumstances and play critical roles in providing care to vulnerable populations.

Our work[5] has shown that the States can divert these funds in ways similar to the enhanced payments provided under the UPL rules. Audits in two States show that public hospitals that received disproportionate share hospital payments returned large portions (80 to 90 percent) of the payments to State Medicaid agencies. Here is an example:

- During fiscal years 1999 and 2000, a State made disproportionate share hospital payments of approximately $738 million to acute care hospitals.
- Approximately $632 million of the $738 million was returned to the State.
- The result was that approximately 86 percent of the total disproportionate share hospital payments were returned to the State via an IGT.

Once payments are returned, the States are able to use the funds for any purpose. We believe the return of these funds contradicts the stated purpose of assisting these public safety-net hospitals to pay for uncompensated care costs. In many States, the use of enhanced payments under the upper payment limit regulations and the disproportionate share program are combined to increase Federal reimbursements. The financial relationship involves some States allowing hospitals to retain upper payment limit funds but requiring the return of disproportionate share hospital funds through IGTs. In other cases, the reverse occurs—hospitals retain disproportionate share hospital funds but return upper payment limit funds.

Just as we recommend for enhanced payments made under the UPL rules, we also believe that disproportionate share hospital funds should remain at the hospitals to provide care to vulnerable populations, rather than being returned to the States through IGTs. We believe that any Medicaid payment returned by a provider to the State should be treated as a refund applicable to the Medicaid program, with a corresponding adjustment to the Federal share.

Disproportionate share hospital payments serve an important purpose in trying to help hospitals cover their uncompensated care costs. But, without States being required to leave the funds at the hospitals, there is no assurance that the intended purpose of disproportionate share payments is being met.

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[5] Reviews in Alabama, North Carolina, and California.

New Vulnerabilities Are Being Identified

We foresee the possibility that all types of public Medicaid providers could be used by States to maximize Federal revenues, circumventing the statutory Federal/State sharing formulas. We are finding other Medicaid program areas where States are manipulating Federal financing sources with little regard for program accountability.

State-employed Physicians and Hospital Graduate Medical Education Payments.

Both State-employed physicians and hospital graduate medical education providers could be paid an enhanced payment that could serve as a mechanism for inflating the Federal share of payments for Medicaid services above the statutory Federal matching percentage. The additional payment amount made to public providers could then be returned to the State by the provider with the effect similar to what we have observed in the UPL enhanced payment process at hospitals and nursing homes.

Medicaid School-based Health Services

Another vulnerability we have noted concerns Medicaid school based health services. States are permitted to use their Medicaid programs to help pay for certain health care services delivered to children in schools, such as physical and speech therapy services. Schools may also receive Medicaid reimbursement for the costs of administrative activities, such as Medicaid outreach activities, application assistance, and coordination and monitoring of health services.

We have identified instances[6] in which States take back funds from the school districts as part of the contractual arrangements or require the districts to return a portion of the Medicaid payment to the State through intergovernmental transfers, thus reducing the State's share of the original payment and possibly resulting in a net gain for the State.

Although not the subject of this hearing, we have found numerous errors in billings for Medicaid services to children by school districts. In many instances, OIG found that school districts billed their States for services that were not supported by documentation, were medically unnecessary, coded incorrectly, or were not covered by the program. In some cases, the school districts billed for services allegedly performed on days the children were not in school. There were also errors in related administrative costs. CMS has begun to recover from some of the States the Federal share of the payments OIG questioned.

Most recently, we released a report of our review of Medicaid speech claims made by the New York City Department of Education.[7] Our objective was to determine whether Federal Medicaid payments for speech services claimed by New York City Department of Education were in compliance with Federal and State requirements. Eighty-six of 100 speech claims in our sample did not comply with requirements and 68 of the sampled claims contained more than 1 deficiency. As a result, we estimate that the State improperly claimed $435,903,456 in Federal Medicaid funding during our audit period.

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[6] Reviews in Washington, Oregon, and New York.

[7] Report A-02-02-01029.

BILLING CONSULTANTS

The use of consultants on a contingency fee basis has become a major influence in helping States to maximize their Medicaid revenue from the Federal government. Although there is nothing wrong with States obtaining such consultant help, it is important that States maintain vigilance over the consultant work to ensure the accuracy of the outcomes. We have noted that selected States have incorrectly billed CMS for claims developed by consultants and for the fees paid to these consultant firms.

In the State of New Jersey, we found that over $22 million in improper Medicaid claims (Federal share of over $11 million) were submitted for prison inmates' inpatient and outpatient health care costs under the Medicaid disproportionate share hospital program. The New Jersey State plan explicitly excluded any Federal funding for the cost of health services provided to prison inmates, and an August 16, 2002, policy clarification by CMS further prohibited Federal disproportionate share reimbursement for prison inmate costs. We found that the State agency relied solely on a consultant's work to prepare claims and, contrary to Federal requirements, failed to ensure the veracity of the claims before submitting them for Federal reimbursement.

The problem in New Jersey was not limited to the prison inmate reimbursement issues noted above. For a 4-year period ending June 30, 2001, this same consultant erroneously duplicated almost $55 million (Federal share over $27 million) in disproportionate share acute care hospital claims that the State submitted to CMS for reimbursement without validating the dollar value. The duplication error by the consultant occurred because their computer system had an error. But the major problem was that the State agency relied solely on the consultant's work to prepare and document the additional disproportionate share acute care hospital claims without validating the consultant's work.

We have also noted instances in which States have claimed unallowable contingency fee payments made to consulting firms for providing Federal revenue maximization services. Such findings were noted in both Virginia and Colorado. Such payments are not allowable for Medicaid reimbursement because the amounts were contingent upon the recovery of costs from the Federal Government, which does not comply with the requirements of Office of Management and Budget Circular A-87.

ACCOUNTABILITY OF MEDICAID FUNDS

As I mentioned at the beginning of this testimony, the financing mechanisms that are designed to circumvent Federal and State cost-sharing principles serve to disguise the source and final use of both Federal and State funds. Such manipulation undermines the ability of Congress and the Department to exercise responsible stewardship of Federal funds and distorts efforts to measure and estimate the true Federal cost of the Medicaid program.

The problems I have described in this statement are just one side of the coin. Not only does the Federal Government pay more than its statutory share of Medicaid because of States' financial manipulations, the Federal Government pays too much for Medicaid as a result of less than optimum State management of other aspects of the program as well.

For example, the Inspector General mentioned a problem with third-party liability claims. Medicaid is supposed to be the payer of last resort. When States pay a claim that should have been paid by another program or insurer, the States have not had great success in recouping those funds. Yet, instead of focusing on cost avoidance, many States pursue a pay–and-chase method of dealing with third-party liability. I am raising these examples here because, when a State pays more for a benefit than it should or pays a claim that some other program or insurer should be paying, not only does the State waste its own tax dollars, the Federal share of that improper payment may be lost as well.

We are in the process of conducting a series of audits of State's accounts receivable systems for Medicaid provider overpayments to determine whether the States reported overpayments to the Federal Government as required. The Social Security Act requires CMS to adjust reimbursements to a State for any overpayment or underpayment and generally requires States to report overpayment adjustments within 60 days from the date of discovery. In the few States reviewed so far, we have identified millions of dollars in provider overpayments for which the States failed to follow reporting rules. Therefore, there were no corresponding adjustments to restore the Federal share of those overpayments.

Effective use of State and Federal Medicaid funds depends on the consistent application of the following widely-accepted accountability principles. Our studies raise serious concerns that some or all of these aspects of accountability are lacking in many State Medicaid programs.

- There should be assurance that the funds paid are actually used for the intended purposes. For example, if disproportionate share payments are made, they must be used to reimburse hospitals for their uncompensated care costs.
- The financial oversight structure should be adequate to ensure that Medicaid funds are paid only for health care services and products that are appropriate and necessary.
- Within the State, there should be a clear trail of responsibility concerning who is accountable for the proper expenditure of Medicaid funds.
- The State Medicaid agency must ensure that quality and timely health care services are being delivered to properly eligible beneficiaries.

CONCLUSION

Our overarching concern is to ensure that Federal matching payments are in proper proportion to States' shares and that the funds are used to provide the intended health care services, in the intended facility, to the intended beneficiaries. Changes are needed to resolve some of the more obvious shortcomings of the Medicaid program that are the subject of this hearing. This concludes my testimony, and I welcome your questions.

A·C·L·I AMERICAN COUNCIL OF LIFE INSURERS
FINANCIAL SECURITY FOR LIFE

Statement

of the

American Council of Life Insurers

On

Medicaid Waste, Fraud, and Abuse: Threatening the Health Care Safety Net

Before the

Senate Finance Committee

of the

United States Congress

June 29, 2005

My name is Joyce Ruddock and I am Vice-President of Long Term Care Insurance at MetLife. Today I am representing MetLife and the American Council of Life Insurers (ACLI), a Washington D. C.-based national trade association representing more than 350 member companies that offer life insurance, annuities, pensions, long-term care insurance, disability income insurance and other retirement and financial protection products. ACLI member companies provide 81 percent of the long-term care insurance coverage in the United States.

By way of background, my professional training is in gerontology and I have worked in long-term care my entire career, first on the service delivery side and then on the financing side. It was clear to me early on that private insurance could be one way to help middle-income Americans pay for long-term care services so that Medicaid could be a safety net for the truly needy. With Medicaid costs rising, accounting for nearly half of all spending on long-term care, the need has never been greater for alternative solutions.

MetLife has been a leader in designing long-term care insurance for nearly twenty years, providing coverage through many of our nation's employers as well as through agents and financial planners. We have the sole endorsement of AARP to provide long-term care insurance to its members and we are one of two carriers offering coverage under the Federal Long-Term Care Insurance Program. As the largest provider of group long-term care insurance and the fastest growing individual carrier, we are pleased to offer a perspective on the market.

We are delighted that this Committee is addressing an important issue facing this nation -- long-term care -- through the hearing process. We applaud Chairman Grassley for drawing attention to this matter, and we are pleased to discuss with the Committee the role that private long-term care insurance plays in helping to provide the retirement security of millions of middle-income families.

To elevate the issue of long-term care today and over the next decade, ACLI cosponsored the 2005 White House Conference on Aging's Mini-Conference on Long-Term Care. At this conference, participants representing long-term care stakeholders within both the public and private sectors came together to actively address the serious issues associated with long-term care and worked to formulate national public policy recommendations to the upcoming White House Conference on Aging that will be held later this year. Hopefully, this effort, along with others, will move the issue forward on the national agenda. Among the several recommendations that the participants developed was urging Congress to enact laws which would encourage private arrangements by individuals and their families for long-term care services, such as tax incentives for the purchase of long-term care insurance or other private options for financing long-term care.

One of the greatest risks to asset loss in retirement is unanticipated long-term care expenses. The risks of needing nursing home care also are substantial. Over half of women and nearly one-third of men 65 and older will stay in a nursing home sometime during their lifetime.[1] The annual cost of a nursing home stay averages $70,000 and is projected to reach $241,000 by 2030.[2] Five visits a week by a home health aide to help with bathing, dressing, and household chores can cost over $1,300 per month.[3] If more hours of home care are needed, the expense is greater. These costs can quickly erode a hard-earned retirement nest egg.

Current Financing for Long-Term Care Services

- **Long-Term Care Insurance**

The long-term care insurance market is evolving and growing in both the individual and group segments. ACLI recently surveyed the long-term care insurance market, with the assistance of America's Health Insurance Plans (AHIP) and found that the market has grown to nearly $7 billion in premiums, covering over 5 million people.

The individual long-term care insurance market grew at 7.5% from 2003 to 2004 (in terms of premiums) and the group market grew at 25%. The average age of purchasers of long-term care insurance continues to decrease to the late 50s as individuals increasingly understand it as a tool to help provide financial security during retirement. Just as the number of people covered by long-term care insurance has increased, so, too, has the amount that has been paid out in claims. In 2004, long-term care insurance carriers paid more than $2.1 billion, or a 20 percent increase from 2003, in long-term care insurance benefits.

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[1] Murtaugh, C.M., P. Kemper, and B.C. Spillman (1990). The Risk of Nursing Home Use in Later Life. *Medical Care* 28(10): 952-62.

[2] MetLife, Mature Market Institute, The MetLife Market Survey of Nursing Home and Home Care Costs, Sept. 2004.

Long-term care insurance products continue to evolve to give policyholders more choices and flexibility at the time of claim. For instance, the market has evolved from one that offered primarily nursing home-only plans early on, to one that offers flexible care options and numerous consumer protections today. Most policies allow customers to choose between in-home care, assisted living facilities and nursing homes, encouraging the individual and their families to customize his or her care needs. In addition, policies offer the services of a care coordinator at the time of claim to help craft a plan of care and identify local care providers. Other common benefits include:

- respite care to provide temporary relief to family caregivers;
- homemaker or chore services;
- restoration of benefits;
- coverage of some medical equipment;
- survivorship benefits;
- payment of family caregivers;
- spousal discounts; and
- paid-up policies.

Plans today are guaranteed renewable, have a 30-day "free look" period, offer inflation protection, cover Alzheimer's disease, have a waiver of premium provision, and offer unlimited benefit periods. Benefits are paid when a person needs help with two or more activities of daily living or is cognitively impaired.

- **Incentives to Encourage Individuals to Buy Long-Term Care Insurance**

An integral part of a solution to finance long-term care will be the passage of S. 1244, the "Long-Term Care and Retirement Security Act of 2005." We thank Chairman Grassley and Senator Lincoln for their sponsorship of this important legislation and applaud their continued support. The measure provides individuals with a phased-in above-the-line federal income tax deduction for the eligible portion of the premiums they pay to purchase long-term care insurance. The long-term care policies eligible for the deduction are subject to broad consumer protections. In addition, the measure would permit long-term care insurance

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[3] "Can Aging Baby Boomers Avoid the Nursing Home? Long-Term Care Insurance for 'Aging in Place'," American Council of Life Insurers, March 2000.

policies to be offered under employer-sponsored cafeteria plans and flexible spending accounts; and would clarify that a qualified long-term care policy could be exchanged tax-free for another qualified long-term care policy better suited to the insured's needs. Finally the bill includes a phased-in tax credit to individuals with long-term care needs or their caregivers of up to $3000.

These important tax incentives will go a long way toward encouraging the purchase of long-term care insurance by middle-income Americans. Moreover, providing these important tax incentives will reduce the burden on the Medicaid system. Individuals will have the ability to pay privately and have the choice of a variety of services and care settings. Today's long-term care insurance policies cover a wide range of services to help people live at home, participate in community life, as well as receive care in a nursing home. This flexibility can enable people who are chronically ill to live in the community and to retain their independence.

While the financial benefits to individual policyholders are obvious, the benefits to government - and future taxpayers - of wider purchase of private long-term care insurance are substantial. By the year 2030, Medicaid's nursing home expenditures could reach $134 billion a year – up 360 percent over 2000 levels. ACLI's research, previously reported in "Can Aging Baby Boomers Avoid the Nursing Home," March 2000, indicates that by paying policyholders' nursing home costs - and by keeping policyholders out of nursing homes by paying for home- and community-based services, private long-term care insurance could reduce Medicaid's institutional care expenditures by $40 billion a year, or about 30 percent.

In addition, the same ACLI study found that wider purchase of long-term care insurance could increase general tax revenues by $8 billion per year, because of the number of family caregivers who would remain at work. Today, according to a recent study by the National Alliance for Caregiving, 6 percent of caregivers quit work to care for an older person; nearly 10 percent have to cut back their work schedules; 17 percent take leaves of absence, and 4 percent turn down promotions because of their caregiving responsibilities.

- **Long-Term Care Partnerships**

Increasingly, states are tackling the costs of long-term care and are exploring ways to partner with the private insurance industry to alleviate the growing burden. One such way is through the *Partnerships for Long-Term Care,* a pilot program developed by the Robert Wood Johnson Foundation in conjunction with state governments and the support of the private insurance industry.

The Partnerships allow consumers to purchase a long-term care policy whose benefits must be fully utilized prior to qualifying for Medicaid. When that coverage is exhausted, individuals may apply for Medicaid, as they would have without the private insurance. Because they utilized their insurance coverage under the Partnership, they can protect the level of assets as defined in their policy.

Partnerships have taken the form of two models. The dollar-for-dollar model allows people to buy a policy that protects a specified amount of assets. The total asset model provides protection for 100 percent of assets once they exhaust their private insurance coverage.

The Partnership program is currently operational in four states: California, Connecticut, Indiana and New York. More than 200,000 long-term care insurance Partnership policies have been purchased in those states, and less than 100 policyholders have exhausted their policies and accessed Medicaid. The Partnership benefits consumers, Medicaid and private insurers.

In 1993, shortly after the Partnership pilots began, Congress suspended expansion of the Partnership to any additional states. The pilots were stopped due to concerns that a publicly funded program such as Medicaid would endorse private insurance programs. Others were concerned that the Partnership might increase Medicaid spending. However, as Medicaid costs increase, Congressional representatives from non-Partnership states have become interested in implementing Partnership programs. During the 108th Congress, legislation was introduced in both the House and the Senate that would repeal that prohibition. In addition, 16 states have passed legislation that would implement a Partnership once the 1993 restrictions are withdrawn or waived. The long-term care insurance industry is interested in expanding the Partnership beyond the four pilot states and is actively engaged in a public policy dialogue that is intended to utilize the lessons learned from those four Programs.

ACLI believes that some type of simplified uniform approach to the long-term care Partnership Program that includes eligibility for benefits for any approved tax-qualified long-term care policy; state reciprocity; dollar for dollar asset protection; uniform, simplified annual reporting to a single repository; and consumer protections can play an important role in encouraging the purchase of long-term care insurance and help provide important savings to Medicaid.

Future Financing for Long-Term Care

Private long-term care insurance can be a significant part of the solution to the future financing of long-term care. But this will require helping families understand the risk they face, through education, and providing them with options and financial incentives to plan ahead. Innovative approaches to combining long-term care benefits with other products such as annuities and life insurance are being explored by the industry. The goal of these approaches is to provide consumers with protection which changes as their life stage changes. Regardless of the approach, both public and private resources will be needed to educate Americans about long-term care and to help them prepare for it.

The insurance industry continues to educate Americans that a financially secure retirement includes a plan to cover future long-term care expenses. To help educate consumers on how to select and purchase a long-term care insurance policy, ACLI maintains educational brochures and information on its website that encourage consumers to do their homework when considering the purchase of long-term care insurance. For example:

(1) look for insurance companies that are reputable, consumer oriented, financially sound and licensed in their particular state,

(2) take time when making a purchase, ask for and read the outline of coverage of several policies,

(3) understand what the policy covers and ask questions to be clear about what the policy is not intended to cover, and

(4) understand when the policy becomes effective, what triggers benefits and if it is tax deductible at the state and/or federal level.

The federal government and the states have also recognized the need to educate individuals in the workplace to plan to cover their future long-term care needs. The federal government, by Act of Congress, has taken the lead and set the example for other employers by offering federal employees and their families the protection of long-term care insurance. Through this program, federal employees are able to help protect their retirement savings from a long-term care event and will have the choice of providing care for themselves or a family member in the home, through assisted living or in a nursing home.

Last year, the Department of Health and Human Services began a federal project to increase awareness among retirees and near-retirees about the need to plan ahead for potential long-term care needs. Governors of five pilot states conducted long-term care awareness campaigns over a three-month period, starting in January 2005. The campaign included press conferences, mailings to 50- to 70 year-olds in each state, advertising and follow-up mailings. The five states include Virginia, Idaho, New Jersey, Nevada and Arkansas. The program is expanding to include additional states.

States are supporting the purchase of long-term care insurance in a number of ways. About half the states have implemented long-term care insurance programs that offer state employees/retirees the opportunity to purchase individual long-term care insurance policies. Twenty-four states provide tax incentives for purchasing long-term care insurance. Most state tax deductions share some features with federal rules – allowing all or part of premiums and expenditures to be deducted. Three states provide a tax deduction or credit for employers offering group long-term care insurance policies. As more than 77 million baby boomers approach retirement, the rapidly aging workforce, together with more employees caring for elderly parents, heighten the importance of long-term care planning as a workplace issue.

In conclusion, we believe that protection and coverage for long-term care is critical to the economic security and peace of mind of all American families. Private long-term care insurance is an important part of the solution for tomorrow's uncertain future. As Americans enter the 21st century, living longer than ever before, their lives can be made more secure knowing that long-term care insurance can provide choices, help assure quality care, and protect their hard-earned savings when they need assistance in the future. We also believe that the costs to Medicaid --- and therefore to tomorrow' s taxpayers --- will be extraordinary as the baby boom generation moves into retirement, unless middle-income workers are encouraged to purchase private insurance now to provide for their own eventual long-term care needs. Education, options, incentives and the efficient use of both public and private resources are critical to our nation's ability to finance long-term care in the decades ahead.

Again, the ACLI looks forward to working with this Committee to help Americans protect themselves against the risk of long-term care needs.

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

TESTIMONY OF

DENNIS G. SMITH

DIRECTOR

CENTER FOR MEDICAID AND STATE OPERATIONS

IN THE

CENTERS FOR MEDICARE & MEDICAID SERVICES

BEFORE THE

COMMITTEE ON FINANCE

ON

MEDICAID FRAUD AND ABUSE

June 28, 2005

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

TESTIMONY OF
DENNIS G. SMITH
DIRECTOR
CENTER FOR MEDICAID AND STATE OPERATIONS
IN THE
CENTERS FOR MEDICARE & MEDICAID SERVICES
ON
MEDICAID OVERSIGHT
BEFORE THE
SENATE FINANCE COMMITTEE

JUNE 28, 2005

Chairman Grassley, Senator Baucus, distinguished Committee members, thank you for inviting me here to discuss the financing of the largest government health insurance program in the United States, Medicaid, and the steps we have taken and are proposing to protect and strengthen the financing of the Medicaid program. Fourteen months ago, I testified before a Congressional subcommittee and presented our view of the problems in Medicaid financing and our strategies for addressing them. I am pleased to share with the Committee our progress and results.

Background

Medicaid is a partnership between the Federal government and the states. While the Federal government provides financial matching payments to the states, each state is responsible for overseeing its Medicaid program, and each state essentially designs and runs its own program within the Federal structure. The Federal government pays the states a portion of their costs through a statutorily determined matching rate, currently ranging between 50 and 77 percent. Over the past two decades, states have developed a number of ways of enhancing Federal matching dollars. There have been numerous studies of these practices over the years from the

Government Accountability Office (GAO) and the Office of the Inspector General (OIG). The problem and descriptions of questionable financing arrangements have been well documented elsewhere as well. Using such arrangements, many states have managed to draw down more Federal Medicaid dollars with fewer state dollars, resulting in an effective match rate that is higher than the statutorily determined match rate. Such practices have resulted in both tensions and inequities among the states and with the Federal government.

Strengthening Program Integrity and Financial Management Activities

We have made substantial progress in identifying states that we believe have used improper payment mechanisms and have set a course of action that will return these states to the appropriate match rates.

In 2002, we created a new team within the Centers for Medicare & Medicaid Services (CMS) to specifically review state plan amendments that involved reimbursement to institutional providers such as nursing homes and hospitals. We subsequently created another group to review plans affecting non-institutional providers such as physicians and clinics. Over time, these teams evolved into the Division of Reimbursement and State Financing (DRSF) in order to consolidate in one CMS component responsibility for all state Medicaid payment policy and state Medicaid funding issues. A central responsibility of this Division is to ensure consistency in the nationwide application of Medicaid payment and funding policy. The Division now comprises three Teams which are responsible for institutional reimbursement, non-institutional reimbursement, and state funding policy and oversight.

Since August 2003, as part of the review process for some 800 state requests for changes in payment methodologies through state plan amendments (SPAs), CMS has been examining information from states regarding detail on how states are financing their share of Medicaid program costs Mr. Chairman, on April 28, 2004, the CMS Administrator replied to your request to be updated on the progress of our state plan reviews. At that time, we had reviewed less than 300 plan amendments. We had identified five states that did not use intergovernmental transfers (IGTs) as a funding mechanism in the provider payment plans we had reviewed; 10 states that used them appropriately; and potential recycling linked to plans in 30 states. At that time, we reported that seven states had worked cooperatively with us to either remove new recycling features or terminate existing provisions. Two of those seven had not implemented recycling provisions.

We now have reviewed more than 800 provider payment plans. As of June 23, 2005, 26 states have revised their financing arrangements dealing with 55 different provider payments. We continue to work with seven states to resolve outstanding financing arrangements.

The President's Proposal – Net Expenditures

We have learned a great deal over the past few years about these financing arrangements and while we have been successful in working through the issues with the states, the history of Medicaid financing including DSH, UPL, and provider taxes shows us that the match rate structure itself tends to create incentives for states to find ways to tip the balance. We share the concerns that GAO has previously expressed that the potential for inappropriate financing exists whenever government entities are also providers. Therefore, we believe that the progress that we have made over the past several years in our review of state financing arrangements should be made permanent. Accordingly, the Administration has proposed specific changes to address the issue of inappropriate funding transfers in the Medicaid program. Fundamentally, the Federal government should only be matching funds (in accordance with the statutorily-defined matching rate) that are actually used to reimburse a provider for the cost of furnishing a Medicaid-covered service to a Medicaid-eligible individual.

In order to assure that Federal matching is only available for a state's actual expenditures, we would propose amending the Medicaid statute so that a state's reported expenditures to any state, county, city, or other local governmental entity or taxing district (including providers owned, employed, or controlled by these entities) could not include any amount paid to the state or local government provider which has returned either directly or indirectly to the state or local government or which is not retained under the ownership and control of the provider for the purpose of furnishing Medicaid care and services.

States would have to provide annual assurances or other information determined by the Secretary that the state is in compliance with the provisions of these proposals. The Secretary is authorized to audit any state that failed to provide sufficient information demonstrating that its report of estimated or actual quarterly expenditures complies with the requirements of this proposal. State plan amendments would not be approved unless the state provided certain information about payments to governmental entities. Failing to provide satisfactory information may result in the Secretary reducing the state's Federal payment or disallowing the claimed expenditure. States, however, would not be held to be out of compliance, nor claimed expenditures disallowed, with respect to payments permitted under an upper payment limit (UPL) transition period. States that inappropriately use recycling arrangements after the effective date of this change would be subject to loss of Federal matching funds. The proposal would be effective with respect to calendar quarters beginning on and after October 1, 2006.

The President's Proposal - Provider Tax Phase Down

Until 1991, when Federal law restricted the use of health care provider related taxes, states were able to tax health care providers as a way to raise their share of the Medicaid matching payment. These funds, used to draw down Federal Medicaid dollars were then returned to the provider, in effect, holding them harmless for the tax they originally paid. This loophole in Federal law permitted states to shift the cost of their Medicaid programs directly to the Federal government.

Despite the 1991 changes in the law, CMS has noticed a recent trend in states' efforts to maximize their revenues through taxation of health care providers. The result is that the Federal government is paying too much.

By reducing the provider tax threshold the Administration is proposing to reduce the amount of cost-shifting that now takes place in some states.

The Administration's proposal would phase-down the maximum limit on the collection of health care-related tax revenues to a limit not to exceed three percent of the net revenues of the taxpaying class of health care providers. The reduction of the limit to three percent would become effective immediately for any health care-related tax programs enacted after the effective date of the Federal legislation. However, states that are currently collecting up to the six percent limit would be given three years to reduce their rate to three percent. The Administration estimates that this change in law would save the Federal government $3.17 billion in FY 2006-FY 2010.

The President's Proposal – Limiting Reimbursement to Medicaid Cost

Currently, payments to individual provider entities owned or operated by state and local governments are not limited to the amount it actually costs to provide medical assistance services. Instead, payment limits to these providers are governed by regulations defining the Medicaid UPL. These regulations limit Medicaid payments for a given service to what Medicare payments would be for the same service.

States have maximized Federal matching payments by claiming expenditures that far exceed their actual costs of providing a service and, through various recycling arrangements, have shifted their costs to the Federal government.

The GAO has repeatedly recommended that "Congress should consider implementing a recommendation…to enact legislation to prohibit Medicaid payments that exceed costs to any government-owned facility."[1]

The Administration proposes to amend the Social Security Act to provide that Medicaid Federal financial participation, or FFP, would not be available for state payments made to state or non-state government-owned or operated facilities or providers which exceed a facility's or provider's actual costs of providing such assistance.

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[1] Allen, Kathryn. "Medicaid: State Financing Schemes Again Drive Up Federal Payments." GAO testimony presented to the U.S. Senate Committee on Finance. September 6, 2000. See also "Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government." GAO/HEHS-94-133, August 1, 1994.

For purposes of determining cost, a variety of sources will be considered, including Medicare reasonable cost payment principles. Cost-based payment limits would be applied on an individual, facility-specific basis to state-owned and non-state owned government providers for services provided, including inpatient hospital services, outpatient hospital services, nursing facility services, ICF-MRs, clinics, physicians, schools, and home and community based waiver services. The cost-based payment limit would replace current regulatory upper payment limits that affect state or non-state government providers. Limits would be calculated on a facility basis for each type of service. The Secretary would develop a uniform methodology for determining the cost of care and services. States would not receive Federal matching funds for payments to these providers to the extent the payment rate in their approved state plan exceeded the cost of care and services.

The changes proposed by the Administration would be effective October 1, 2006. Together with the net expenditure proposal, the President's Budget projects $5.9 billion in savings over five years. CBO has not yet scored these proposals.

The President's Proposal – Medicaid Administrative Claiming

The President's Budget proposes to curtail inefficient Medicaid administrative spending patterns by establishing an allotment for Medicaid administrative claiming.

Under the Administration's proposal, the Federal government would establish a state-specific limit on the amount of Federal matching funds available for the costs of state and local administration of the Medicaid program, by establishing an administrative costs allotment for each state. State administrative costs allotments would be based on the administrative costs for each state for a base year. The Administration estimates that this provision would save $1.1 billion between FY 2006 and FY 2010.

The President's Proposal – Clarifying the Definition of Rehabilitation Services

Under current practices, states are billing Medicaid for rehabilitation services that are intrinsic elements of non-Medicaid programs. In reviewing plan amendments, we realize that the definition of rehabilitation services is so broad that there is risk for Federal dollars to be inappropriately claimed. The Administration proposes to prevent this cost shifting by statutorily excluding payment for rehabilitation services that are intrinsic to programs other than Medicaid. The proposal clarifies that Medicaid payments **will be** available for appropriate rehabilitation services that are intended for the maximum reduction of physical or mental disability and measurable restoration of an individual to the best possible functional level.

The proposal will ensure that payment is excluded for rehabilitation services if the services are routinely furnished without charge, are not billed under a fee schedule, or are not provided with respect to a specific individual.

The President's Proposal –Clarifying the Definition of Case Management

In a similar vein, we also believe that it is appropriate to prevent Medicaid from being billed for **other** activities that are intrinsic elements of non-Medicaid programs. For example, CMS has determined that the costs of services that are part of the administration of programs such as foster care, the Individuals with Disabilities Education Act (IDEA), and state adult and juvenile justice programs are being shifted to Medicaid by some states.

In one state where millions of dollars had been claimed under Medicaid for case management services to fund the administrative costs of a state's foster care program, CMS found that court appearances, crisis counseling, training of parents and transportation services related to foster care and child welfare were claimed as Medicaid case management.

The Administration proposes to put an end to this cost shifting by statutorily excluding payment for case management services that are a part of programs other than Medicaid. Additionally, the Administration seeks to lower reimbursement for targeted case management services to the administrative match rate of 50 percent.

The proposal clarifies that Medicaid payment **will be** available for case management services that will assist individuals in gaining access to needed medical, social, educational, and other services, so long as the case management services are distinct from these other services, and designed to achieve specific, measurable health care outcomes.

The Administration estimates that the changes to target case management and rehabilitation services will save $3 billion over five years.

In addition to these legislative proposals for clarifying the definition of rehabilitation services and case management, the Administration proposes to codify Medicaid "free care" policy in regulation.

The President's Proposal - Restructuring Medicaid Pharmacy Payment to Use Average Sales Price (ASP)

Under current law pharmacies are paid for drugs they dispense to Medicaid beneficiaries based on the lower of the pharmacy's estimated acquisition cost (EAC) plus a reasonable dispensing fee, or their usual and customary charges to the general public.

States generally use published commercial compendia prices as the basis for establishing EAC. That is, states use average wholesale price (AWP) and apply a discount (generally in the range of 10 percent to 15 percent); or states might use wholesale acquisition cost (WAC) plus a percentage markup.

For multiple source drugs with sufficient competition in the market (generic drugs), CMS sets a Federal Upper Payment Limit (FUL) on Medicaid drug payment. To set the FUL, CMS selects the lowest price (AWP, WAC or Direct Price) and multiplies it by 150% as required in regulations to arrive at the FUL. If a state sets its EAC above the FUL, CMS will only pay

Federal matching funds up to the FUL, rather than for the full amount of the state-established EAC.

In addition to payments for the drugs themselves, states add a *dispensing fee* that covers all of the cost of services that the pharmacy provides to dispense the drug, including pharmacy overhead, salaries and profit. The regulations require that this dispensing fee be reasonable. The states currently have options as to how they will establish EAC and dispensing fees. In some states these payment amounts are set by state legislation. In other states, studies are done as to what the amounts should be. Sometimes, states will look to what neighboring states are paying.

Under the current system, states have not been able to easily compare their rates with those of private payers as those payers have held their rates to be proprietary and confidential. States have also generally not been able to audit the prices that pharmacists pay in any systematic manner because of the administrative burden of keeping up with approximately 50,000 active National Drug Codes on the market.

Unfortunately, this statutorily established system results in inflated payment for Medicaid drugs. AWP is a list price that is set by a drug manufacturer for their products and most states use AWP as a basis for establishing EAC. Pharmacies acquire the drugs from the manufacturer for a cost that is usually much lower than the AWP. The difference between the pharmacy acquisition cost and the reimbursed amount is referred to as the "spread." The larger the "spread" the more a pharmacy profits on the reimbursement from Medicaid. This system has created an incentive for manufacturers to artificially raise the AWP to make their products more attractive to pharmacies because the profit will be larger with the higher AWP. Pharmacies will stock and fill generic prescriptions with products that have the widest spread, thus resulting in the greatest profit. This has led to ever increasing AWPs and an ever increasing imbalance between what Medicaid pays and true market prices.

The President's Budget proposes to require state Medicaid programs to use the Average Sales Price (ASP) of a prescription drug to the pharmacy as the basis for reimbursement. The ASP is defined as the actual price at which a manufacturer sold a prescription drug to the pharmacy or wholesaler. Currently CMS collects ASP data from manufacturers for use in establishing prices for most drugs payable under Part B of the Medicare program. Using ASP in the Medicaid program would establish a similar price reporting system for both Medicare and Medicaid, making that process simpler for manufacturers to comply with. However, because Part B covers only a limited number of drugs, the ASP reporting would need to substantially increase to include all of the Medicaid covered drugs.

The President's proposal would require states to pay pharmacies a reasonable dispensing fee of six percent of ASP to compensate the pharmacy for the storage, dispensing, and counseling that they provide for Medicaid beneficiaries. This is consistent with Medicare reimbursement under Part B established under the Medicare Modernization Act of 2003 (MMA).

This proposal would give states flexibility in the way in which they pay for drugs. For example, states could reimburse at a rate higher than 106 percent of ASP for a generic drug, and less than 106 percent of ASP for a brand name drug, so long as in the aggregate the state is paying 106 percent of ASP per quarter. This would continue to encourage the use of generic substitutes in the Medicaid prescription drug program. States could also pay rural pharmacies a higher rate to encourage access.

The Administration estimates that this proposal would save $542 million in the first year, and $5.4 billion over 5 years. CBO estimates that this proposal would save $947 million in the first year, and $5.2 billion over 5 years.

The President's Proposal – Amending the Medicaid Drug Rebate Formula

The Medicaid program requires all drug manufacturers to pay a rebate for all drugs covered by Medicaid. The calculations for this rebate involve a figure called lowest private market price, or best price. This figures functions as a price floor. The Administration proposes replacing best price with a budget neutral flat rebate.

The President's Proposal - Addressing Asset Transfers

Current law requires individuals applying for Medicaid long-term care services to spend all but a minimum level of assets before becoming eligible. However, creative estate planning often allows individuals to become eligible for Medicaid without using their own assets for needed care first.

When an individual who applies for Medicaid has transferred assets within the look-back period (currently 3 years for transfers to natural persons, and 5 years for transfers to trusts), the value of those assets are counted in determining a period of ineligibility for long term care services under Medicaid.

However, the penalty period for such asset transfers currently begins to run on the date of the asset transfer. The result is that at the end of the look-back period, the individual is free to shift the burden for paying for long-term care to the Medicaid program, and in some extreme cases, for assets transferred within the look-back period, the penalty period could be over before the individual even requires long term care services or applies for Medicaid.

The President's proposal would begin the penalty period upon the later of (1) the asset transfer; or (2) the point at which an individual is getting Medicaid and is receiving long-term care services either in an institution or, in certain circumstances, in the community. This would prevent individuals from planning ahead and transferring their assets so that the penalty period expires prior to their needing long-term care.

The Administration estimates this change would save $99 million for the first year, and $1.5 billion over five years. CBO estimates this would save $260 million for the first year, and $1.4 billion over five years.

Medicaid Oversight Activities

Medicaid oversight involves at least two distinct and equally important functions. The first, financial management involves the oversight of state claims for Medicaid and SCHIP Federal reimbursement which includes the monitoring of Federal payments. This is distinct from our second function which is to prevent and identify efforts to defraud the Medicaid program, generally by providers but occasionally by beneficiaries who most often are in collusion with providers. CMS and states need to partner to prevent and control these criminal acts because we are both victimized by these unscrupulous providers.

Both financial management review and fraud and abuse prevention and control activities need to be done to ensure overall program integrity. Financial management oversight requires that CMS audit and survey states to assure that tax payer dollars are not misspent. For fraud and abuse prevention and control, we must partner with the states because of the mutuality of interest. These are two different problems with two different solutions that require flexibility in the use of very limited staffing resources.

Financial Management Review Activities

To improve the internal controls related to the Medicaid program to ensure a strong oversight function, CMS is in the process of hiring 100 new financial management staff. As of June 14, 2005, we had hired 97 FTEs to monitor state activities and enforce compliance with CMS financial management procedures and improve Medicaid financial management oversight. Ninety of the staff are allocated to specific states and 10 of these staff are based in Central Office. Extensive training for these new hires was conducted in September 2004, late February of 2005, and April of 2005 with additional training planned for September of this year.

Since that training, the new staff have begun making the necessary contacts with their respective Medicaid agencies to gain a thorough understanding of the overall organizational structure of the state's Medicaid program; the programmatic structure of the state's Medicaid program; and the state budget, expenditure, and financial management processes. They have been working closely with current Regional Office and state financial management staff on these activities.

These new employees have met with numerous health officials in their respective states, attended public hearings regarding the 2006 state budgets, and have performed significant research of public records, and participated in financial management reviews with current Regional Office staff. They will be integrated into the review of Medicaid reimbursement state plan issues, perform reviews of state funding issues, assist in the resolution of OIG and GAO audit findings, and perform other financial oversight activities. Through their work, and through coordination with the Regional Offices, we will prevent new versions of inappropriate financing arrangements before they are put in place and replicated. The President's Budget alerts Congress to one of these new versions dealing with provider taxes on Medicaid-only managed care organizations and we have urged the adoption of legislation to close this loophole that will surely get bigger without Congressional action.

Additionally, as discussed previously, CMS recently consolidated our reimbursement review teams and created a Division of Reimbursement and State Financing (DRSF) within the Centers for Medicaid and State Operations (CMSO) to consolidate in one component responsibility for all state Medicaid payment policy and state Medicaid funding issues. A central responsibility of this Division is to ensure consistency in the application nationwide of Medicaid payment and funding policy. The 10 new Central Office staff noted above are housed in this Division. The Division comprises three Teams which are responsible for institutional reimbursement, non-institutional reimbursement, and state funding policy and oversight. As part of this integrated approach, there are bi-weekly conference calls with DRSF and each Regional Office, in which we discuss pending Medicaid reimbursement SPAs and Medicaid financial management issues in the respective regional offices. Through these bi-weekly calls, we develop a cross-representational team that is equipped to address the full range of Medicaid reimbursement and financial issues in each state within each region. These calls began on February 7, 2005.

Contingency Fee Contracts

A large number of states have used consultants, paid on a contingency fee basis, to implement projects to maximize their Federal Medicaid reimbursements. A number of the schemes created by these consultants have inappropriately inflated the Federal share of funding and CMS has moved to stop this practice. In May of 2002 and again in November of that year, CMS sent memoranda to its Regional Offices clarifying that except in certain limited cases, contingency fees are not permissible administrative expenses and should not be the cause of any Federal matching funds going to the states. Contingency fee consultants have helped states maximize the Federal dollars flowing into their systems through manipulation of targeted case management, rehabilitation services, supplemental payment arrangements, school-based services, and administrative costs. CMS has taken action in each of these areas, including disallowances, financial management reviews, OIG contracted audits, disapproval of state plan amendments, and legislative recommendations to Congress.

Fraud and Abuse Activities

When considering fraud and abuse reduction efforts in the Medicaid program it is critical to remember that this is a joint Federal-state effort and that both levels of government have people devoted to preventing and addressing fraud. CMS works with the states, and uses its own systems as well, to prevent fraud and abuse prior to their occurrence, a more efficient model than attempting to find and prosecute fraudulent actors after the fact.

Federal regulations require that each state Medicaid agency maintain a Medicaid Management Information System (MMIS). The MMIS is a claims payment and information retrieval system. A vital part of each state's MMIS is the Surveillance and Utilization Review Subsystem (SURS). SURS is a mandatory component of MMIS. Each state also has a unit of the same name. The principal purpose of the SURS unit, utilizing the subsystem, is to safeguard against inappropriate payments for Medicaid services. This is done by analyzing and evaluating provider service utilization in order to identify patterns of fraudulent, abusive, unnecessary and/or inappropriate utilization.

Each MMIS must be Federally certified before funding is granted. CMS utilizes multidisciplinary teams to conduct comprehensive, onsite reviews before such certification is granted. CMS funds 90 percent of the administrative costs associated with the start up of each state's MMIS and then continues to fund each state at a 75 percent Federal match for the ongoing operations of these systems. In FY 2003, CMS' share for the funding of these state systems was over $1.5 billion.

When the SURS identify suspected fraud cases, they refer them to the State Medicaid Fraud Control Units (MFCUs), another element of the Federal-state partnership to protect the Medicaid system. In FY 2003, the MFCUs recovered $268 million in court restitutions, fines, civil monetary penalties and were instrumental in obtaining 1,096 convictions. A total of 538 individuals and entities were excluded from participating in the Medicare and Medicaid programs based on referrals made to the OIG by the MFCUs.

Medicaid Alliance for Program Safeguards

In an effort to better coordinate Medicare and Medicaid program integrity, CMS, in partnership with the State of California, initiated a project, known as Medi-Medi, designed to share and analyze both Medicare and Medicaid data beginning in 2001. Comparing data from both of these programs revealed fraudulent patterns previously invisible to either program, independent of the other.

Participants in this project include staff from CMS' Central Office and San Francisco Regional Office, the California Department of Health Services, the FBI (Central and Regional offices), the Assistant United States Attorneys, the California Attorney General's Office, and the Department of Health and Human Services' Office of Inspector General.

The project uncovered a number of fraudulent schemes. For example, Medi-Medi discovered one provider who was billing 32 hours of services on a single day, 16 hours to each program. Although 16 hours worth of services is a high amount, it is not impossible and would be passed over by either program independent of the knowledge of what was going on in the other program. In another scheme, a number of providers were found to be submitting bills designed to be rejected by Medicare, submitting the bill to Medicaid for full payment (as opposed to the 20 percent Medicaid would pay after Medicare paid 80 percent), then resubmitting a clean, "payable" bill to Medicare for full Medicare payment.

Since the inception of the original Medi-Medi Data Match Project in California in FY 2001, CMS has allocated just over $23,000,000 in Health Care Fraud and Abuse Control (HCFAC) funds for the continuation of the California project and for the expansion of the original Medi-Medi project to eight (8) additional states. The FBI also provided nearly $7,000,000, bringing the total funding for the Medi-Medi Data Match Project to $30,000,000 between FY 2001 and FY 2005.

One of the major benefits established by the California data match project was that it yielded templates for a Scope of Work (SOW), and Computer Matching Agreements (CMA) for use by the expansion states. This has enabled the expansion process for newly participating states to move along more quickly.

CMS finalized the necessary SOWs and CMAs with the expansion states of Texas, Illinois, Pennsylvania, North Carolina, Florida, and New Jersey. These expansion states began data sharing in May 2004. Recently, CMS added the states of Ohio and Washington to this project and they have recently finalized their CMAs. They will likely begin data matching in FY05.

To date, tracking reports that include the State of California and the six expansion states that are currently operational indicate a total of approximately $199 million worth of cost avoidances, savings, and recoveries. To date, 240 investigations have been opened and are in various stages of development with 28 cases having been referred to law enforcement. Our Administrator, Dr. Mark McClellan, has publicly expressed his strong support for this program. CMS plans to continue and expand these efforts.

School-Based Services

There is always some confusion regarding Medicaid payment of services versus the costs associated with administering them. With regard to payment of administrative services by Medicaid, which may include administrative functions related to providing transportation services, the Centers for Medicare & Medicaid Services (CMS) issued the Medicaid School-Based Administrative Claiming Guide (the Guide) on May 28, 2003. The Guide is intended to address the requirements for claiming the costs of Medicaid related administrative activities – including those related to transportation -- performed in schools. It is not intended to address or change existing requirements for providing Medicaid services in the school setting and claiming for related service expenditures.

In 1997, CMS issued a technical assistance guide that contained specific information on Medicaid requirements associated with seeking payment for coverable school-based services. This included specific guidance on transportation services. In 1999, CMS sent all state Medicaid Directors a letter providing further guidance on reimbursement for school-based health services under Medicaid.

Currently, the Office of the Inspector General is conducting audits in multiple states involving claims for school-based health services. The objective of the audits is to determine if Medicaid payments for school-based health services are in accordance with applicable laws and regulations. To date, OIG has issued final reports in eleven states. Its audit work has shown that Federal Medicaid funds were claimed for (1) services that were not approved in the state plan, (2) services that were not sufficiently documented to ensure that services prescribed in the students' individualized educational plans (IEP) were delivered, (3) services that were not authorized or were in excess of the quantity authorized in the IEP, (4) transportation services when there was no authorized Medicaid service on the same day, (5) services rendered by health care providers that did not have the qualifications required by Medicaid regulations, (6) services provided free to other students, and (7) students who were absent. OIG's audit work in this area continues.

As noted, the Department has already issued guidance to states to help them understand what administrative services Medicaid will reimburse.

Payment Accuracy Measurement Project/Payment Error Rate Measurement (PAM/PERM)

In July of 2001, CMS announced a demonstration project, known as Payment Accuracy Measurement (PAM), to work with states in developing model methodologies to measure the accuracy of payments made for Medicaid services. CMS was interested in methodologies that multiple states could use so that the Agency could develop a national payment accuracy rate.

CMS took this step at the urging of Congress, the GAO and the Office of Management and Budget (OMB).

A payment accuracy rate establishes a base to:

- identify the extent of problems in the payment system;
- study causes; and
- strengthen internal controls.

The goals of the study team established under this demonstration project were to:

- overcome the various obstacles to identifying payment errors;
- foster experimentation to identify successful strategies and practices that would help public payers in future PAM projects; and
- help CMS gain perspective on the conceptual and practical challenges facing states in implementing Medicaid payment accuracy measurement systems.

The Payment Accuracy Measurement Project (PAM) methodology has been developed and pilot tested with extensive collaboration from participating states during a four-year research and demonstration project.

In the first year, FY 2002, the pilot study was conducted in 9 states, which expanded to 12 states in the second year, and to 27 states in the third year. This year, the fourth year, 30 states are participating and the project was re-named the Payment Error Rate Measurement (PERM) project. Twenty four of the states are pilot testing the CMS methodology in their Medicaid and SCHIP programs; three states are pilot testing the methodology in their SCHIP-only program;

and three states are pilot testing the methodology in their Medicaid-only program. The ultimate goal of the PAM is the national implementation of a Medicaid and SCHIP Payment Error Rate Measurement (PERM) project.

Survey and Certification of Facilities

In addition to the efforts laid out above, CMS maintains oversight of the survey and certification of nursing homes and continuing care providers including hospitals, nursing homes, home health agencies, end-stage renal disease facilities, hospices, and other facilities serving Medicare and Medicaid beneficiaries, and makes available to beneficiaries, providers/suppliers, researchers and state surveyors information about these activities. Periodic surveys of these institutions are preformed by state agencies, under the direction of CMS, and reports are then made to CMS concerning the results. These efforts help not only to ensure that the appropriate conditions of participation are being met by the providers, but that they are not engaging in waste, fraud and abuse.

Conclusion

We are proud of the progress we have made to date in protecting the integrity of the financing of the Medicaid program. We know our work is not over and that we must be ready to predict and respond to new developments. The President's Budget describes areas for your consideration in ensuring these actions will be enduring. Thank you again for the opportunity to speak with you today. I look forward to answering any questions you might have.

Questions for the Record From Senator Grassley
Senate Finance Committee Hearing on
Medicaid Fraud and Abuse
Witness: Dennis G. Smith
June 28, 2005

Question 1: Newly Hired Employees at CMS

During the hearing there was discussion among a number of witnesses regarding CMS' hiring of 100 new employees. Will you state on the record that these 100 new employees hired by CMS will be used for the purpose of detecting and preventing fraud, waste and abuse in the Medicaid program?

More specifically, will you devote a portion of these individuals to reviewing and overseeing intergovernmental transfers?

Answer:

To improve the internal controls related to the Medicaid program in order to ensure a strong oversight function, CMS is in the process of hiring 100 new financial management staff. As of August 12, 2005, we have hired 99 FTEs to ensure that states are appropriately financing their Medicaid programs in accordance with Federal law and regulation and improve Medicaid financial management oversight. Ninety of the staff are allocated to specific states and 10 of these staff are based in Central Office. Extensive training for these new hires was conducted in September 2004, late February of 2005, and April of 2005 with additional training planned for September of this year.

During FY 2005, these FTEs are undergoing intensive training and working to gain a thorough understanding of the overall organizational structure of the State's Medicaid program; the programmatic structure of the State's Medicaid program; and the State budget, expenditure, and financial management processes. By Federal FY 2006, the 100 Medicaid FTEs will have an integral role in ensuring that all proposals and practices in Medicaid reimbursement and state financing, including use of intergovernmental transfers, are consistent with the statutory design of a Federal-State partnership.

In FY 2005, the FTEs are already involved in approximately 45 new financial management reviews regarding state financing of Medicaid expenditures under state plan amendments. In 2006, the goal is for the new FTEs to assist in reduction of the Federal share of Medicaid expenditures at risk by 10% nationally and to work with states to identify newly proposed Medicaid funding sources.

Question 2: State Plan Amendments and Consultant Assistance

The role that consultants play in crafting and developing state plan amendments appears to be an indicator that a plan amendment may be utilizing revenue maximization strategies. Why hasn't CMS developed a process to identify state plan amendments and claims that have been developed with assistance of consultants when it has identified expenditures related to contingency fees as high-risk?

Answer:

Although CMS does not have the authority to require states to disclose their use of contingency-fee consultants (CFCs) in their submissions of State plan amendments (SPAs), cost allocation plans (CAPs), and expenditure reports, we fully recognize that they can be a factor associated with risk in the Medicaid program. In that regard, while we do not generally require the disclosure of CFC arrangements, we are committed to reviewing all SPAs, CAPs and expenditure reports to the fullest extent possible under our authority to determine the allowability of states' claims and programs consistent with all relevant federal requirements.

CMS has made substantial progress in identifying states that we believe have used improper payment mechanisms and have set a course of action that will return these states to the appropriate match rates. The process we use for identifying improper payment mechanisms is applied to all requests for state plan amendments, regardless of whether or not a consultant was used to formulate them. The use by a state, of a consultant, is not prima fascia evidence of an improper payment mechanism and therefore, although we are aware that some consultants have assisted in establishing improper payment mechanisms, we have not adopted review strategies that focus purely on whether or not a state uses such consultants.

Question 3: Targeted Case Management and Rehabilitation Services

The President's 2006 budget states that CMS wants to clarify current policies as to when and under what circumstances a state can appropriately claim targeted case management and rehabilitation services. Can you summarize the proposed clarification that CMS would like to make, the status of the proposal and the basis for the estimated savings from these proposal as set forth in the budget?

Answer:

The President's case management proposal would amend the definition of "case management services" under Medicaid to clarify that such services are those which assist individuals in obtaining necessary medical, social, educational, and other services, so long as they (1) are distinct from such other services; (2) are used to achieve specific, measurable outcomes for specific individuals, and (3) are not required services or an administrative function of another program. This section also provides for disallowance of State expenditures on case management services if such services are routinely provided in the State without charge, are not billed under a fee schedule, or are not provided with respect to a specific individual. States would be required to provide adequate assurances that their quarterly reports of expenditures do not include those for which Federal matching is so disallowed, and the Secretary authorized to audit State plans toward this end and to reduce, defer, or disallow such non-compliant State expenditures.

The rehabilitation proposal would amend the definition of "rehabilitation services" to clarify that such services are those necessary for the achievement of specific, measurable outcomes related to restoration of an individual to his or her best possible functional level, so long as they are prescribed and furnished by (or under the supervision of) a physician or other licensed practitioner and are not provided as an intrinsic element of another program. This section also provides for disallowance of State expenditures on rehabilitation services if such services are routinely provided in the State without charge, are not billed under a fee schedule, or are not provided with respect to a specific individual. States would be required to provide adequate assurances that their quarterly reports of expenditures do not include those for which Federal matching is so disallowed, and the Secretary authorized to audit State plans toward this end and to reduce, defer, or disallow such non-compliant State expenditures.

On August 5, 2005, Secretary Leavitt transmitted these and other Medicaid proposals to the Speaker of the House of Representatives and to the President of the Senate. As estimated by CMS actuaries, the FY 2006 President's Budget includes a combined total savings of $2 billion from 2006-2010 for clarifying the definition of case management and rehabilitation services.

Questions for the Record From Senator Baucus
Senate Finance Committee Hearing on
Medicaid Fraud and Abuse
Witness: Dennis G. Smith
June 28, 2005

Question 1:

The President's budget included a number of proposals to change federal oversight of state financing mechanisms, including intergovernmental transfers, targeted case management, administrative changes, and others, but little detail was offered on how these proposals would be implemented. When can we expect to see the specific legislative proposals and the basis for the savings referred to in the President's budget? Can you provide us with state-by-state impact data for each of these proposals?

Answer:

On August 5, 2005 Secretary Leavitt formally transmitted draft legislation for these and other Medicaid proposals to the Speaker of the House of Representatives and to the President of the Senate.

The Office of the Actuary does not prepare state-by-state impact analyses of legislative proposals.

Question 2:

In your response to GAO's report on Medicaid consultants, you report that 23 states have agreed to terminate one or more financing practices, at the end of their fiscal year in 2005 and that CMS is working with 10 more states. Can you describe which financing practices are prohibited under the current policy and how much Medicaid expenditures will decrease as a result of these enforcement efforts?

Answer:

First to provide an update, as of August 12, 2005, 26 states have agreed to terminate one or more financing practices and CMS is working cooperatively with 7 more states.

Through the State Plan Amendment (SPA) review process, CMS discovered that several states make claims for federal matching funds associated with Medicaid payments to health care providers, even though the health care providers are not ultimately allowed to receive or retain these payments. Instead through the "guise" of intergovernmental transfers (IGTs) states and/or local governments require the health care provider to forgo and/or return certain Medicaid payments to the state, which effectively shifts the cost of the Medicaid program to the Federal taxpayer.

The result of such an arrangement is that the health care provider is unable to retain the full Medicaid payment amount to which it was entitled (even though federal funding was made available based on the full payment), and the state and/or local government may use the funds returned by the health care provider for costs outside the Medicaid program and/or to help draw additional Federal dollars for other Medicaid program costs. The net effect of this re-direction of Medicaid payments is that the Federal government bears a greater level of actual Medicaid program costs than the Federal statute authorizes.

Question 3:

CMS' current enforcement strategy appears to entail reviewing states as they submit plan amendments or waiver requests.

- **a. What is your strategy for ensuring compliance among the states that are not submitting plan amendments or waivers?**
- **b. What mechanisms do you have in place to ensure consistency and fairness across states?**
- **c. What data can you provide to back up your assertion that CMS enforcement policies are uniform and consistent for all states? Have internal reviews been conducted to determine there are no discrepancies in policy or outcome?**

Answer:

(a) There is a multi-tiered strategy for developing, focusing and enhancing CMS resources in the oversight of the Medicaid program. Beginning with FY 2002, CMS developed and institutionalized a structured Regional Office Financial Management (FM) work plan, incorporating an intensive planning process with a consistent and centralized national approach for reviewing states' claims. An integral component of the work plan is identifying areas of high risk and performing focused FM reviews in such areas.

Our current financial management review process is outlined in our work plan for FY 2005 which is attached. For those areas where we have notified a state that there is a concern with their financing of the non-federal share of their Medicaid program, we have instructed our Regional Offices to conduct a financial management review to document issues and develop a course of corrective action.

(b) In 2002, we created a new team within the Centers for Medicare & Medicaid Services (CMS) to specifically review state plan amendments that involved reimbursement to institutional providers such as nursing homes and hospitals. In 2003, we created another team to review plans affecting non-institutional providers, such as physicians and clinics. In January 2005, the Division of Reimbursement and State Financing (DRSF) was created to consolidate in one CMS component responsibility for all state Medicaid reimbursement policy and state Medicaid financing issues. A central responsibility of this Division is to ensure consistency in the nationwide application of Medicaid reimbursement and financing policy. The Division now comprises three teams which are responsible for institutional reimbursement, non-institutional reimbursement, and state financing policy and oversight. Each of these teams meets internally weekly to discuss reimbursement and state financing proposals. Further, our non-institutional team meets monthly to discuss policies and issues with all of our Regional Offices.

Since August 2003, CMS has been requesting information from states regarding detail on how they are financing their share of Medicaid program costs under the Medicaid reimbursement State Plan Amendment (SPA) review process. The questions related to state financing are applied consistently and equally to all states under the SPA review process. CMS will not approve new SPA proposals until states have fully explained how they finance their Medicaid programs and until such time that states have agreed to terminate any financing practices that contradict the spirit of the Federal-state partnership. In addition, follow-up audits are conducted for any questionable financing practice that is discovered as part of the Medicaid reimbursement SPA review.

We now have reviewed more than 850 state requests for changes in payment methodologies through SPAs. As of August 12, 2005, 26 states have revised their financing arrangements related to 62 different provider payments. We continue to work cooperatively with 7 states to resolve outstanding financing arrangements.

Other mechanisms in place to achieve consistency include increased integration of activities with our Regional Offices and the recent hiring of the 100 new Medicaid financial management specialists/accountants. Specifically, we have:

- As of August 12, 2005, hired 99 FTEs to ensure that states are appropriately financing their Medicaid programs in accordance with Federal and regulation and to improve Medicaid financial management oversight. Ninety of the staff are allocated to specific states and 10 of these staff are based in Central Office.
- Held formal 2-week training sessions, in September 2004 and February 2005, to provide an understanding of policy and operations related to Medicaid reimbursement and state financing to new staff.
- Convened two national conferences, one held in April 2005 and the other in September 2005, for financial management staff to exchange information, resolve issues, share best practices and discuss FM reviews and audits.
- Scheduled monthly meetings with each Regional Office, wherein we discuss all pending Medicaid reimbursement proposals and all the Medicaid financial management issues in the respective Regional Office.
- Scheduled monthly teleconferences with all of the new 100 FTEs to discuss specific issues relative to their functions.

(c) As noted above, the Division of Reimbursement and State Financing was created in order to consolidate in one CMS component responsibility for all state Medicaid reimbursement policy and state Medicaid financing issues. A central responsibility of this Division is to ensure consistency in the nationwide application of Medicaid reimbursement and financing policy. The Division now comprises three Teams which are responsible for institutional reimbursement, non-institutional reimbursement, and state financing policy and oversight.

In addition, for each SPA that has terminated an impermissible financing arrangement, through our Regional Offices, we are performing financial management reviews of impermissible financing arrangements to ensure uniform application and confirm compliance with termination provisions. Further, we are also verifying through detailed reviews of the CMS-64 submissions for the quarter ending September 30, 2005 compliance with termination of impermissible financing arrangements.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

(Date Stamped: JAN 25 2005)

TO: All Regional Administrators

FROM: Director
Center for Medicaid and State Operations

SUBJECT: Regional Office (RO) Medicaid/State Children's Health Insurance Program (SCHIP) Financial Management (FM) Workplans for Fiscal Year (FY) 2005--ACTION

This memorandum and attachments describe the regional office (RO) Medicaid and SCHIP Financial Management (FM) Workplans for FY 2005, which you submitted in response to my November 8 request, and which I now ask that you proceed to implement. The national and RO specific FM workplans have been established to address continued concerns which were identified in reports by the General Accounting Office and the Chief Financial Officer. The workplan provides for a structured Medicaid and SCHIP FM review process, with particular emphasis on on-site FM reviews in high risk areas of states' programs. In keeping with that emphasis, we have established, and the attached FY 2005 workplans incorporate, a standard of at least one significant FM review per FTE per fiscal year. Accordingly, your individual RO workplans reflect this standard. We expect that you will commit the staffing and travel resources necessary to successfully carry out the work reflected in your approved FY 2005 FM Workplan.

As you know, the FM Workplan process has two parts. Step One is development of the Workplan itself, which is based on the Center for Medicaid and State Operations' (CMSO) review of your submissions. After CMSO's review of the RO proposed workplans, and incorporation of any revisions that you and we agree are appropriate, CMSO compiles the national and RO-specific FM Workplan (which is attached for FY 2005).

Step Two of the Workplan process is to track FM activities and accomplishments throughout the FY. Following the end of each quarter, you will be asked to submit a quarterly FM Activities Report (FMAR). The format will be the same as the basic FM Workplan, as shown in the attachments to this memorandum. The FM personnel costs, however, will be reported only on the fourth quarterly report, for the entire fiscal year.

Additionally, the FMAR includes a column for ROs to provide narrative information for four key FM activity line items: Cost Allocation Plans (Line 1), Administrative Claiming Plans (Line 2), Focused Financial Management Reviews (Line 9), and On-site Quarterly Expenditure Reviews (Line 14A). The FMAR is due 30 days after the end of each quarter. Accordingly, the report for the quarter ending December 31, 2004, will be due by January 30, 2005.

We recognize that it may be necessary to revise the National or RO specific workplans, based on current events or a need to redeploy resources. Any requests by a RO to revise the FM workplan should be submitted by the Associate Regional Administrator to Edward Gendron, for review and approval, with a copy to Richard Strauss.

If there are questions about this request, please contact me or ask your staff to contact Richard Strauss at (410) 786-2019.

Sincerely,

/s/

Dennis G. Smith

Attachments

cc:
Associate Regional Administrators
Division of Medicaid and State Operations

RO FM Branch Chiefs

Attachment 1

NATIONAL AND RO SPECIFIC MEDICAID/SCHIP FM WORKPLANS FOR FY 2005

The following provides a brief description of the attached Excel spreadsheet (FY2005FMWPlan1.xls) containing the national (worksheet: "National FM Workplan") and RO specific (worksheet: "RO xx") FY 2005 RO FM Workplan. On each of the attached RO specific workplans the cells in which information was provided by the ROs are highlighted in pale yellow. The information is presented under 15 FM activity line items, which are grouped under 3 overall categories (I. Front – End Financial Management, II. Ongoing FM Oversight/Enforcement and III. Quarterly Reviews). Each RO provided the indicated information; this information has been compiled into the national and RO specific workplans for FY 2005.

- Column A - Financial Management Activities. Column A briefly describes the 15 FM activity line item categories.

- Column B - Total Full-Time Equivalents (FTEs). Each RO entered at the top of Column B the total non-supervisory FTEs projected to be working on the FM activities during the fiscal year. Each RO entered on each indicated FM activity line item in Column B the level of FTEs projected to be working on that activity during the fiscal year. The Grand Total All Areas of the RO entries on each line is calculated at the bottom of Column B. In order to assure proper entry by the ROs on each line, the Grand Total All Entries calculated from the entries on each line must equal the total entered at the top of the column; if it does not, the word "ERROR" will be displayed in the Grand Total.

- Column C - Percent of Total FTEs. The percentage on each line of Column C is automatically calculated based upon the data entered in Column B; it is equal to the FTE level for each line of Column B divided by the grand total for all FTEs at the bottom of Column B.

- Column D - Number of Activities Completed. Each RO entered on each FM activity line item of Column D the projected number of such activities to be completed during the fiscal year.

- Column E - Activities Per FTE. The entry on each activity line item in Column E is automatically calculated; it is equal to the number of activities completed and entered in Column D divided by the number of FTEs entered in Column B.

- Column F - Personnel Cost Per Activity. Each RO entered at the top of Column F the total projected personnel costs for the fiscal year. The entry for personnel costs on each FM activity line item in Column F is automatically calculated by multiplying the percentages calculated in Column C by the total projected costs entered at the top of Column F.

- Column G - Travel Cost Per Activity. Each RO entered at the top of Column G the total projected travel costs for each FM activity line item for the fiscal year. Each RO entered on each indicated FM activity line item in Column G the travel costs projected for that activity during the fiscal year. The Grand Total All Areas of the RO entries on each line is calculated at the bottom of Column G. In order to assure proper entry by the ROs on each line, the Grand Total All Entries calculated from the entries on each line must equal the total entered at the top of the column; if it does not, the word "ERROR" will be displayed in the Grand Total.

The National FM Workplan, the RO specific workplan worksheets, and the other worksheets contained in the attached Excel file (file: FY2005FMWorkPlan1.xls), are briefly described below:

- Worksheet: NATIONAL FM WORKPLAN. This worksheet is a summary compilation of the RO specific workplans. The columns of this worksheet are described above.
- Worksheet: NO. of Activities. This worksheet is a breakout of Column D (Number of Activities Completed), by RO, from the National workplan.
- Worksheet: FTEs. This worksheet is a breakout of Column B (Total FTEs), by RO, from the National workplan.
- Worksheet: RO xx. There are ten of these worksheets, representing one for each of the ROs, which reflect the RO workplan submittals. The columns of this worksheet are described above.

Also attached, is an Excel file (file: 2005FMReviews.xls) which provides by State and subject category, the projected focused FM reviews projected for FY 2005. There are two worksheets in this file:

- Worksheet: ALPHABETIC. This worksheet orders the States alphabetically in presenting the focused FM reviews.
- Worksheet: RO. This worksheet orders the States by RO in presenting the focused FM reviews.

Attachments (Excel files):
FY2005FMWorkPlan1.xls
2005FMReviews.xls

FY 2005 FM WORKPLAN - FOCUSED REVIEWS

STATE	TOTAL	Family Planning Claims	IGTs	Insurance Reimbmt.	Pharmacy Benefit Manager	Transpt. Costs	TCM Services	DSH Payments	Nursing Salary Costs	Undocumented Aliens	SCHIP	Non MMIS Claims	SPMP	Nursing Home Assmt.	Hospital Reimbmt.	Mental Health Rehab Services	MCO	Contract Costs	FQHC	UPL	Enhanced Payments
Alabama	1		1																		
Alaska	2																				
Arizona	1																				
Arkansas	1										1										
California	3						1														
Colorado	2														1	1					
Connecticut	1	1																			
Delaware	-																				
District of Columbia	1															1					
Florida	1																			1	
Georgia	-																				
Hawaii	1																				
Idaho	1	1																			
Illinois	1																	1			
Indiana	2																			1	
Iowa	-																				
Kansas	2																				
Kentucky	1																				1
Louisiana	2							1											1		
Maine	-																				
Maryland	1																1				
Massachusetts	2			1		1															
Michigan	2																				
Minnesota	1		1																		
Mississippi	1		1																		
Missouri	2																				
Montana	-																				
Nebraska	1																				
Nevada	1												1								
New Hampshire	1				1																
New Jersey	3	1						1	1												
New Mexico	1																				
New York	6									1	1	1	1	1	1						
North Carolina	1																				
North Dakota	-																				
Ohio	2																				
Oklahoma	1																				
Oregon	1																				
Pennsylvania	1																	1			
Rhode Island	1					1															
South Carolina	1																				
South Dakota	-																				
Tennessee	1																				
Texas	1																				
Utah	1						1														
Vermont	1						1														
Virginia	-																				
Washington	1									1											
West Virginia	1																		1		
Wisconsin	2																				
Wyoming	-																				
TOTAL	61	3	3	1	1	2	3	2	1	2	2	1	2	1	2	2	1	2	2	2	1

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FY 2005 FM WORKPLAN - FOCUSED REVIEWS

STATE	Provider Overpymts.	Source of Funds	Admin Claims	IP Hospital Services	School Based Claims	APD Claims	Nurse Aide Training Costs	Prior Approval/ Equipment Purchases	HCBS Waiver	High Cost Case Mgmt.	High Volume Provider Pymts.	Parent Fee Program	Juvenile Delinquent/ Detention Center	LTC Institutional Reimbsmt.	CPEs	MMIS	OP Hospital Services	Personal Care Services	Indian HS Facilities/ Non-Native
Alabama																			
Alaska																		1	1
Arizona			1																
Arkansas																			
California	1																1		
Colorado																			
Connecticut																			
Delaware																			
District of Columbia																			
Florida																			
Georgia																			
Hawaii				1															
Idaho																			
Illinois																			
Indiana			1																
Iowa																			
Kansas												1	1						
Kentucky																			
Louisiana																			
Maine																			
Maryland																			
Massachusetts																			
Michigan					1	1													
Minnesota																			
Mississippi																			
Missouri														1	1				
Montana																			
Nebraska																1			
Nevada																			
New Hampshire																			
New Jersey																			
New Mexico	1																		
New York																			
North Carolina	1																		
North Dakota																			
Ohio							1	1											
Oklahoma	1																		
Oregon	1																		
Pennsylvania																			
Rhode Island																			
South Carolina		1																	
South Dakota																			
Tennessee			1																
Texas											1								
Utah																			
Vermont																			
Virginia																			
Washington																			
West Virginia																			
Wisconsin									1	1									
Wyoming																			
TOTAL	5	1	3	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

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Worksheet: ALPHABETIC

FY 2005 FM WORKPLAN - FOCUSED REVIEWS

STATE	TOTAL	Family Planning Claims	IGTs	Insurance Reimbsmt.	Pharmacy Benefit Manager	Transpt. Costs	TCM Services	DSH Payments	Nursing Salary Costs	Undocumented Aliens
Connecticut	1	1	-	-	-	-	-	-	-	-
Maine	-	-	-	-	-	-	-	-	-	-
Massachusetts	2	-	-	1	-	1	-	-	-	-
New Hampshire	1	-	-	-	1	-	-	-	-	-
Rhode Island	1	-	-	-	-	1	-	-	-	-
Vermont	1	-	-	-	-	-	1	-	-	-
TOTAL RO 1	6	1	-	1	1	2	1	-	-	-
New Jersey	3	1	-	-	-	-	-	1	1	-
New York	6	-	-	-	-	-	-	-	-	1
TOTAL RO 2	9	1	-	-	-	-	-	1	1	1
Delaware	-	-	-	-	-	-	-	-	-	-
District of Columbia	1	-	-	-	-	-	-	-	-	-
Maryland	1	-	-	-	-	-	-	-	-	-
Pennsylvania	1	-	-	-	-	-	-	-	-	-
Virginia	-	-	-	-	-	-	-	-	-	-
West Virginia	1	-	-	-	-	-	-	-	-	-
TOTAL RO 3	4	-	-	-	-	-	-	-	-	-
Alabama	1	-	1	-	-	-	-	-	-	-
Florida	1	-	-	-	-	-	-	-	-	-
Georgia	-	-	-	-	-	-	-	-	-	-
Kentucky	1	-	-	-	-	-	-	-	-	-
Mississippi	1	-	1	-	-	-	-	-	-	-
North Carolina	1	-	-	-	-	-	-	-	-	-
South Carolina	1	-	-	-	-	-	-	-	-	-
Tennessee	1	-	-	-	-	-	-	-	-	-
TOTAL RO 4	7	-	2	-	-	-	-	-	-	-
Illinois	1	-	-	-	-	-	-	-	-	-
Indiana	2	-	-	-	-	-	-	-	-	-
Michigan	2	-	-	-	-	-	-	-	-	-
Minnesota	1	-	1	-	-	-	-	-	-	-
Ohio	2	-	-	-	-	-	-	-	-	-
Wisconsin	2	-	-	-	-	-	-	-	-	-
TOTAL RO 5	10	-	1	-	-	-	-	-	-	-
Arkansas	1	-	-	-	-	-	-	-	-	-
Louisiana	2	-	-	-	-	-	-	1	-	-
New Mexico	1	-	-	-	-	-	-	-	-	-
Oklahoma	1	-	-	-	-	-	-	-	-	-
Texas	1	-	-	-	-	-	-	-	-	-
TOTAL RO 6	6	-	-	-	-	-	-	1	-	-
Iowa	-	-	-	-	-	-	-	-	-	-
Kansas	2	-	-	-	-	-	-	-	-	-
Missouri	2	-	-	-	-	-	-	-	-	-
Nebraska	1	-	-	-	-	-	-	-	-	-
TOTAL RO 7	5	-	-	-	-	-	-	-	-	-
Colorado	2	-	-	-	-	-	-	-	-	-
Montana	-	-	-	-	-	-	-	-	-	-
North Dakota	-	-	-	-	-	-	-	-	-	-
South Dakota	-	-	-	-	-	-	-	-	-	-
Utah	1	-	-	-	-	-	1	-	-	-
Wyoming	-	-	-	-	-	-	-	-	-	-
TOTAL RO 8	3	-	-	-	-	-	1	-	-	-
Arizona	1	-	-	-	-	-	-	-	-	-
California	3	-	-	-	-	-	1	-	-	-
Hawaii	1	-	-	-	-	-	-	-	-	-
Nevada	1	-	-	-	-	-	-	-	-	-
TOTAL RO 9	6	-	-	-	-	-	1	-	-	-
Alaska	2	-	-	-	-	-	-	-	-	-
Idaho	1	1	-	-	-	-	-	-	-	-
Oregon	1	-	-	-	-	-	-	-	-	-
Washington	1	-	-	-	-	-	-	-	-	1
TOTAL RO 10	5	1	-	-	-	-	-	-	-	1
TOTAL ALL ROs	61	3	3	1	1	2	3	2	1	2

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FY 2005 FM WORKPLAN - FOCUSED REVIEWS

STATE	SCHIP	Non MMIS Claims	SPMP	Nursing Home Assmt.	Hospital Reimbsmt.	Mental Health Rehab Services	MCO	Contract Costs	FQHC	UPL	Enhanced Payments
Connecticut	-	-	-	-	-	-	-	-	-	-	-
Maine	-	-	-	-	-	-	-	-	-	-	-
Massachusetts	-	-	-	-	-	-	-	-	-	-	-
New Hampshire	-	-	-	-	-	-	-	-	-	-	-
Rhode Island	-	-	-	-	-	-	-	-	-	-	-
Vermont	-	-	-	-	-	-	-	-	-	-	-
TOTAL RO 1	-	-	-	-	-	-	-	-	-	-	-
New Jersey	-	-	-	-	-	-	-	-	-	-	-
New York	1	1	1	1	1	-	-	-	-	-	-
TOTAL RO 2	1	1	1	1	1	-	-	-	-	-	-
Delaware	-	-	-	-	-	-	-	-	-	-	-
District of Columbia	-	-	-	-	-	1	-	-	-	-	-
Maryland	-	-	-	-	-	-	1	-	-	-	-
Pennsylvania	-	-	-	-	-	-	-	1	-	-	-
Virginia	-	-	-	-	-	-	-	-	-	-	-
West Virginia	-	-	-	-	-	-	-	-	1	-	-
TOTAL RO 3	-	-	-	-	-	1	1	1	1	-	-
Alabama	-	-	-	-	-	-	-	-	-	-	-
Florida	-	-	-	-	-	-	-	-	-	1	-
Georgia	-	-	-	-	-	-	-	-	-	-	-
Kentucky	-	-	-	-	-	-	-	-	-	-	1
Mississippi	-	-	-	-	-	-	-	-	-	-	-
North Carolina	-	-	-	-	-	-	-	-	-	-	-
South Carolina	-	-	-	-	-	-	-	-	-	-	-
Tennessee	-	-	-	-	-	-	-	-	-	-	-
TOTAL RO 4	-	-	-	-	-	-	-	-	-	1	1
Illinois	-	-	-	-	-	-	-	1	-	-	-
Indiana	-	-	-	-	-	-	-	-	-	1	-
Michigan	-	-	-	-	-	-	-	-	-	-	-
Minnesota	-	-	-	-	-	-	-	-	-	-	-
Ohio	-	-	-	-	-	-	-	-	-	-	-
Wisconsin	-	-	-	-	-	-	-	-	-	-	-
TOTAL RO 5	-	-	-	-	-	-	-	1	-	1	-
Arkansas	1	-	-	-	-	-	-	-	-		-
Louisiana	-	-	-	-	-	-	-	-	1	-	-
New Mexico	-	-	-	-	-	-	-	-	-	-	-
Oklahoma	-	-	-	-	-	-	-	-	-	-	-
Texas	-	-	-	-	-	-	-	-	-	-	-
TOTAL RO 6	1	-	-	-	-	-	-	-	1	-	-
Iowa	-	-	-	-	-	-	-	-	-	-	-
Kansas	-	-	-	-	-	-	-	-	-	-	-
Missouri	-	-	-	-	-	-	-	-	-	-	-
Nebraska	-	-	-	-	-	-	-	-	-	-	-
TOTAL RO 7	-	-	-	-	-	-	-	-	-	-	-
Colorado	-	-	-	-	1	1	-	-	-	-	-
Montana	-	-	-	-	-	-	-	-	-	-	-
North Dakota	-	-	-	-	-	-	-	-	-	-	-
South Dakota	-	-	-	-	-	-	-	-	-	-	-
Utah	-	-	-	-	-	-	-	-	-	-	-
Wyoming	-	-	-	-	-	-	-	-	-	-	-
TOTAL RO 8	-	-	-	-	1	1	-	-	-	-	-
Arizona	-	-	-	-	-	-	-	-	-	-	-
California	-	-	-	-	-	-	-	-	-	-	-
Hawaii	-	-	-	-	-	-	-	-	-	-	-
Nevada	-	-	1	-	-	-	-	-	-	-	-
TOTAL RO 9	-	-	1	-	-	-	-	-	-	-	-
Alaska	-	-	-	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	-	-	-	-	-	-
Oregon	-	-	-	-	-	-	-	-	-	-	-
Washington	-	-	-	-	-	-	-	-	-	-	-
TOTAL RO 10	-	-	-	-	-	-	-	-	-	-	-
TOTAL ALL ROs	2	1	2	1	2	2	1	2	2	2	1

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FY 2005 FM WORKPLAN - FOCUSED REVIEWS

STATE	Provider Overpymts.	Source of Funds	Admin Claims	IP Hospital Services	School Based Claims	APD Claims	Nurse Aide Training Costs	Prior Approval/ Equipment Purchases	HCBS Waiver	High Cost Case Mgmt.
Connecticut	-	-	-	-	-	-	-	-	-	-
Maine	-	-	-	-	-	-	-	-	-	-
Massachusetts	-	-	-	-	-	-	-	-	-	1
New Hampshire	-	-	-	-	-	-	-	-	-	-
Rhode Island	-	-	-	-	-	-	-	-	-	-
Vermont	-	-	-	-	-	-	-	-	-	-
TOTAL RO 1	-	-	-	-	-	-	-	-	-	1
New Jersey	-	-	-	-	-	-	-	-	-	-
New York	-	-	-	-	-	-	-	-	-	-
TOTAL RO 2	-	-	-	-	-	-	-	-	-	-
Delaware	-	-	-	-	-	-	-	-	-	-
District of Columbia	-	-	-	-	-	-	-	-	-	-
Maryland	-	-	-	-	-	-	-	-	-	-
Pennsylvania	-	-	-	-	-	-	-	-	-	-
Virginia	-	-	-	-	-	-	-	-	-	-
West Virginia	-	-	-	-	-	-	-	-	-	-
TOTAL RO 3	-	-	-	-	-	-	-	-	-	-
Alabama	-	-	-	-	-	-	-	-	-	-
Florida	-	-	-	-	-	-	-	-	-	-
Georgia	-	-	-	-	-	-	-	-	-	-
Kentucky	-	-	-	-	-	-	-	-	-	-
Mississippi	-	-	-	-	-	-	-	-	-	
North Carolina	1	-	-	-	-	-	-	-	-	-
South Carolina	-	1	-	-	-	-	-	-	-	-
Tennessee	-	-	1	-	-	-	-	-	-	-
TOTAL RO 4	1	1	1	-	-	-	-	-	-	-
Illinois	-	-	-	-	-	-	-	-	-	-
Indiana	-	-	1	-	-	-	-	-	-	-
Michigan	-	-	-	-	1	1	-	-	-	-
Minnesota	-	-	-	-	-	-	-	-	-	-
Ohio	-	-	-	-	-	-	1	1	-	-
Wisconsin	-	-	-	-	-	-	-	-	1	-
TOTAL RO 5	-	-	1	-	1	1	1	1	1	-
Arkansas	-	-	-	-	-	1	-	-	-	-
Louisiana	-	-	-	-	-	-	-	-	-	-
New Mexico	1	-	-	-	-	-	-	-	-	-
Oklahoma	1	-	-	-	-	-	-	-	-	-
Texas	-	-	-	-	-	-	-	-	-	-
TOTAL RO 6	2	-	-	-	-	1	-	-	-	-
Iowa	-	-	-	-	-	-	-	-	-	-
Kansas	-	-	-	-	-	-	-	-	-	-
Missouri	-	-	-	-	-	-	-	-	-	-
Nebraska	-	-	-	-	-	-	-	-	-	-
TOTAL RO 7	-	-	-	-	-	-	-	-	-	-
Colorado	-	-	-	-	-	-	-	-	-	-
Montana	-	-	-	-	-	-	-	-	-	-
North Dakota	-	-	-	-	-	-	-	-	-	-
South Dakota	-	-	-	-	-	-	-	-	-	-
Utah	-	-	-	-	-	-	-	-	-	-
Wyoming	-	-	-	-	-	-	-	-	-	-
TOTAL RO 8	-	-	-	-	-	-	-	-	-	-
Arizona	-	-	1	-	-	-	-	-	-	-
California	1	-	-	-	-	-	-	-	-	-
Hawaii	-	-	-	1	-	-	-	-	-	-
Nevada	-	-	-	-	-	-	-	-	-	-
TOTAL RO 9	1	-	1	1	-	-	-	-	-	-
Alaska	-	-	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	-	-	-	-	-
Oregon	1	-	-	-	-	-	-	-	-	-
Washington	-	-	-	-	-	-	-	-	-	-
TOTAL RO 10	1	-	-	-	-	-	-	-	-	-
TOTAL ALL ROs	5	1	3	1	1	2	1	1	1	1

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FY 2005 FM WORKPLAN - FOCUSED REVIEWS

STATE	High Volume Provider Pymts.	Parent Fee Program	Juvenile Delinquents/ Detention Centers	LTC Institutional Reimbsmt.	CPEs	MMIS	OP Hospital Services	Personal Care Services	Indian HS Facilities/ Non Native	RO
Connecticut	-	-	-	-	-	-	-	-	-	1
Maine	-	-	-	-	-	-	-	-	-	1
Massachusetts	-	-	-	-	-	-	-	-	-	1
New Hampshire	-	-	-	-	-	-	-	-	-	1
Rhode Island	-	-	-	-	-	-	-	-	-	1
Vermont	-	-	-	-	-	-	-	-	-	1
TOTAL RO 1	-	-	-	-	-	-	-	-	-	
New Jersey	-	-	-	-	-	-	-	-	-	2
New York	-	-	-	-	-	-	-	-	-	2
TOTAL RO 2	-	-	-	-	-	-	-	-	-	
Delaware	-	-	-	-	-	-	-	-	-	3
District of Columbia	-	-	-	-	-	-	-	-	-	3
Maryland	-	-	-	-	-	-	-	-	-	3
Pennsylvania	-	-	-	-	-	-	-	-	-	3
Virginia	-	-	-	-	-	-	-	-	-	3
West Virginia	-	-	-	-	-	-	-	-	-	3
TOTAL RO 3	-	-	-	-	-	-	-	-	-	
Alabama	-	-	-	-	-	-	-	-	-	4
Florida	-	-	-	-	-	-	-	-	-	4
Georgia	-	-	-	-	-	-	-	-	-	4
Kentucky	-	-	-	-	-	-	-	-	-	4
Mississippi	-	-	-	-	-	-	-	-	-	4
North Carolina	-	-	-	-	-	-	-	-	-	4
South Carolina	-	-	-	-	-	-	-	-	-	4
Tennessee	-	-	-	-	-	-	-	-	-	4
TOTAL RO 4	-	-	-	-	-	-	-	-	-	
Illinois	-	-	-	-	-	-	-	-	-	5
Indiana	-	-	-	-	-	-	-	-	-	5
Michigan	-	-	-	-	-	-	-	-	-	5
Minnesota	-	-	-	-	-	-	-	-	-	5
Ohio	-	-	-	-	-	-	-	-	-	5
Wisconsin	-	-	-	-	-	-	-	-	-	5
TOTAL RO 5	-	-	-	-	-	-	-	-	-	
Arkansas	-	-	-	-	-	-	-	-	-	6
Louisiana	-	-	-	-	-	-	-	-	-	6
New Mexico	-	-	-	-	-	-	-	-	-	6
Oklahoma	-	-	-	-	-	-	-	-	-	6
Texas	1	-	-	-	-	-	-	-	-	6
TOTAL RO 6	1	-	-	-	-	-	-	-	-	
Iowa	-	-	-	-	-	-	-	-	-	7
Kansas	-	1	1	-	-	-	-	-	-	7
Missouri	-	-	-	1	1	-	-	-	-	7
Nebraska	-	-	-	-	-	1	-	-	-	7
TOTAL RO 7	1	1	1	1	1	1	-	-	-	
Colorado	-	-	-	-	-	-	-	-	-	8
Montana	-	-	-	-	-	-	-	-	-	8
North Dakota	-	-	-	-	-	-	-	-	-	8
South Dakota	-	-	-	-	-	-	-	-	-	8
Utah	-	-	-	-	-	-	-	-	-	8
Wyoming	-	-	-	-	-	-	-	-	-	8
TOTAL RO 8	-	-	-	-	-	-	-	-	-	
Arizona	-	-	-	-	-	-	-	-	-	9
California	-	-	-	-	-	-	1	-	-	9
Hawaii	-	-	-	-	-	-	-	-	-	9
Nevada	-	-	-	-	-	-	-	-	-	9
TOTAL RO 9	-	-	-	-	-	-	1	-	-	
Alaska	-	-	-	-	-	-	-	1	1	10
Idaho	-	-	-	-	-	-	-	-	-	10
Oregon	-	-	-	-	-	-	-	-	-	10
Washington	-	-	-	-	-	-	-	-	-	10
TOTAL RO 10	-	-	-	-	-	-	-	1	1	
TOTAL ALL ROs	2	1	1	1	1	1	1	1	1	

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Worksheet: RO

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005						
Region (Enter I - X):	I-X					SUMMARY FOR RO I-X
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO I-X =	Percent of Total FTEs RO I-X	Number Of Activities Completed RO I-X	FTE Per Activity RO I-X	Personnel Cost Per Activity TOTAL for RO I-X	Travel Cost Per Activity TOTAL for RO I-X
	62.42				$5,073,094.00	$197,897.65
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	2.31	3.70%	119	0.20	$189,561.96	$22.05
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	1.32	2.11%	39	0.23	$108,487.52	$1,663.78
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.91	1.46%	114	0.07	$73,823.57	$6,257.25
4. Financial Administrative Policy Technical Assistance	2.59	4.15%	878	0.03	$212,211.53	$1,052.46
SUBTOTAL I.A.	7.14	11.43%	NA	NA	$583,884.58	$8,995.54
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	1.95	3.13%	207	0.10	$162,430.48	$891.86
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	2.02	3.24%	143	0.19	$165,348.06	$2,268.80
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	1.85	2.97%	122	0.24	$151,863.08	$6,316.77
8. Financial Program Policy Technical Assistance	4.07	6.52%	1176	0.04	$334,359.50	$2,009.01
SUBTOTAL I.B.	9.89	15.85%	NA	NA	$814,001.10	$11,488.43
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	9.91	15.88%	63	1.27	$799,194.28	$64,717.06
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	1.91	3.06%	69	0.30	$155,981.46	$3,088.10
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	4.23	6.78%	163	0.22	$340,581.77	$4,621.79
12. Deferrals and Disallowances	4.19	8.71%	153	0.28	$337,953.36	$2,207.50
13. Financial Data & Information Gathering (e.g., UPL, schools)	4.49	7.20%	823	0.05	$364,960.63	$2,146.25
SUBTOTAL II.	24.73	39.62%	NA	NA	$1,998,651.49	$76,780.70
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	11.78	18.84%	191	0.53	$941,893.38	$80,175.22
B. Desk Reviews In Regional Office	4.15	8.64%	153	0.36	$350,323.19	$1,021.76
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	2.84	4.55%	153	0.18	$228,402.85	$19,022.43
B. Desk Reviews In Regional Office	1.91	3.06%	174	0.11	$158,137.42	$215.56
SUBTOTAL III.	20.66	33.10%	NA	NA	$1,676,556.84	$100,434.97
GRAND TOTAL ALL AREAS	62.42	100.00%	NA	NA	$5,073,094.00	$197,697.65

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN–FOR FISCAL YEAR 2005						
Region (Enter I - X):	I					SUMMARY FOR RO I
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO I =	Percent of Total FTEs RO I	Number Of Activities Completed RO I	FTE Per Activity RO I	Personnel Cost Per Activity TOTAL for RO I	Travel Cost Per Activity TOTAL for RO I
	7.00				$594,110.00	$6,000.00
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.14	2.05%	9	0.02	$12,196.71	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.08	1.14%	9	0.01	$6,790.10	$43.23
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.02	0.21%	0	na	$1,273.14	$0.00
4. Financial Administrative Policy Technical Assistance	0.34	4.81%	52	0.01	$28,558.72	$444.51
SUBTOTAL I.A.	0.58	8.22%	NA	NA	$48,818.66	$487.74
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.11	1.51%	2	0.05	$8,956.56	$34.50
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.18	2.64%	29	0.01	$15,687.24	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.15	2.15%	5	0.03	$12,795.09	$0.00
8. Financial Program Policy Technical Assistance	0.53	7.57%	74	0.01	$44,999.23	$707.61
SUBTOTAL I.B.	0.97	13.88%		NA	$82,438.12	$742.11
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	1.14	16.35%	7	0.16	$97,111.09	$2,514.60
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.31	4.36%	3	0.10	$25,887.24	$0.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.62	8.87%	24	0.03	$52,674.16	$60.89
12. Deferrals and Disallowances	0.28	4.00%	25	0.01	$23,765.33	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.96	13.72%	170	0.01	$81,483.27	$0.00
SUBTOTAL II.	3.31	47.28%	NA	NA	$280,921.10	$2,575.49
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	1.15	16.36%	38	0.03	$97,183.24	$894.00
B. Desk Reviews In Regional Office	0.46	6.51%	10	0.05	$38,697.18	$1,021.76
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.35	4.96%	38	0.01	$29,494.48	$63.33
B. Desk Reviews In Regional Office	0.20	2.79%	10	0.02	$16,557.22	$215.56
SUBTOTAL III.	2.14	30.62%	NA	NA	$181,932.12	$2,194.65
GRAND TOTAL ALL AREAS	7.00	100.00%	NA	NA	$594,110.00	$6,000.00

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005						
REGION (ENTER I - X):	II					SUMMARY FOR RO II
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO II =	Percent of Total FTEs RO II	Number Of Activities Completed RO II	FTE Per Activity RO II	Personnel Cost Per Activity TOTAL for RO II	Travel Cost Per Activity TOTAL for RO II
	9.00				$098,815.00	$4,500.00
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.36	4.00%	15	0.02	$27,944.80	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.02	0.22%	0	na	$1,552.48	$0.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.00	0.00%	0	na	na	$0.00
4. Financial Administrative Policy Technical Assistance	0.16	1.78%	68	0.00	$12,419.82	$0.00
SUBTOTAL I.A.	0.54	6.00%	83	NA	$41,916.90	$0.00
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.00	0.00%	0	na	na	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.09	1.00%	8	0.01	$8,088.15	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.18	1.78%	2	0.08	$12,419.82	$1,485.00
8. Financial Program Policy Technical Assistance	0.15	1.67%	28	0.01	$11,643.58	$0.00
SUBTOTAL I.B.	0.40	4.44%	38	NA	$31,049.56	$1,485.00
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	1.13	12.56%	10	0.11	$87,714.99	$450.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.18	2.00%	6	0.03	$13,972.30	$2,565.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.75	8.33%	15	0.05	$58,217.92	$0.00
12. Deferrals and Disallowances	0.95	10.56%	34	0.03	$73,742.69	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.75	8.33%	122	0.01	$58,217.92	$0.00
SUBTOTAL II.	3.76	41.78%	187	NA	$291,865.82	$3,015.00
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	2.50	27.78%	18	0.16	$194,059.72	$0.00
B. Desk Reviews in Regional Office	0.50	5.56%	8	0.06	$38,811.94	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	1.10	12.22%	18	0.07	$85,386.28	$0.00
B. Desk Reviews in Regional Office	0.20	2.22%	8	0.03	$15,524.78	$0.00
SUBTOTAL III.	4.30	47.78%	48	NA	$333,782.72	$0.00
GRAND TOTAL ALL AREAS	9.00	100.00%	356	NA	$898,615.00	4,500.00

CURRENT REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT ACTIVITIES--FOR FY 2005						
Region III:	III	SUMMARY FOR RO III				
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	Total FTEs For RO III =	Percent of Total FTEs RO III	Number Of Activities Completed RO III	FTE Per Activity RO III	Personnel Cost Per Activity Total for RO III	Travel Cost Per Activity RO III
	3.75				$275,220.00	$11,131.00
I. Front-End Financial Management						
A. Administrative Program Development						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.09	2.40%	7	0.01	$8,605.28	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.06	1.60%	3	0.02	$4,403.52	$0.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.02	0.53%	2	0.01	$1,467.84	$0.00
4. Financial Administrative Policy Technical Assistance	0.28	7.47%	107	0.00	$20,549.76	$0.00
SUBTOTAL I.A.	0.45	12.00%	119	NA	$33,026.40	$0.00
B. Services Program Development						
5. Medicaid & SCHIP Program Non-institutional State Plan Amendments (e.g., TCM, schools)	0.00	0.00%	0		$0.00	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.07	1.87%	4	0.02	$5,137.44	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.23	8.13%	8	0.04	$18,880.18	$0.00
8. Financial Program Policy Technical Assistance	0.40	10.67%	116	0.00	$29,356.80	$0.00
SUBTOTAL I.B.	0.70	18.87%	128	NA	$51,374.40	$0.00
II. Ongoing FM Oversight/Enforcement						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	0.48	12.80%	4	0.12	$35,228.16	$3,950.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.33	8.80%	10	0.03	$24,219.36	$500.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.26	6.93%	16	0.02	$19,081.92	$0.00
12. Deferrals and Disallowances	0.12	3.20%	8	0.02	$8,807.04	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.42	11.20%	81	0.01	$30,824.64	$0.00
SUBTOTAL II.	1.61	42.93%	97	NA	$118,181.12	$4,450.00
III. Quarterly Reviews						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	0.75	20.00%	10	0.08	$55,044.00	$6,681.00
B. Desk Reviews in Regional Office	0.13	3.47%	38	0.00	$9,540.96	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.00	0.00%	0	na	$0.00	$0.00
B. Desk Reviews in Regional Office	0.11	2.93%	48	0.00	$8,073.12	$0.00
SUBTOTAL III.	0.99	28.40%	96	NA	$72,658.08	$6,681.00
GRAND TOTAL ALL AREAS	3.75	100.00%	438	NA	$275,220.00	$11,131.00

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005						
REGION (ENTER I - X):	IV					SUMMARY FOR RO IV
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO IV =	Percent of Total FTEs RO IV	Number Of Activities Completed RO IV	FTE Per Activity RO IV	Personnel Cost Per Activity TOTAL for RO IV	Travel Cost Per Activity TOTAL for RO IV
	7.92				$612,861.00	$30,400.00
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.13	1.64%	4	0.03	$10,059.59	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.22	2.78%	0	na	$17,023.92	$0.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.32	4.04%	36	0.01	$24,762.08	$0.00
4. Financial Administrative Policy Technical Assistance	0.37	4.67%	51	0.01	$28,631.13	$0.00
SUBTOTAL I.A.	1.04	13.13%	NA	NA	$80,478.70	$0.00
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-institutional State Plan Amendments (e.g., TCM, schools)	0.38	4.80%	48	0.01	$29,404.95	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.35	4.42%	22	0.02	$27,083.50	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.41	5.18%	24	0.02	$31,728.39	$600.00
8. Financial Program Policy Technical Assistance	0.67	10.98%	183	0.00	$67,321.85	$800.00
SUBTOTAL I.B.	2.01	25.38%	NA	NA	$155,536.69	$1,200.00
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	1.25	15.78%	8	0.16	$98,726.80	$11,200.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.25	3.16%	23	0.01	$19,345.36	$0.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.33	4.17%	13	0.03	$25,535.88	$0.00
12. Deferrals and Disallowances	0.37	4.67%	5	0.07	$28,631.13	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.49	6.19%	74	0.01	$37,916.91	$0.00
SUBTOTAL II.	2.69	33.96%	NA	NA	$208,156.07	$11,200.00
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	0.89	11.24%	21	0.04	$68,869.48	$14,900.00
B. Desk Reviews In Regional Office	0.54	6.82%	9	0.06	$41,785.98	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.36	4.55%	10	0.04	$27,857.32	$3,100.00
B. Desk Reviews In Regional Office	0.39	4.92%	22	0.02	$30,178.76	$0.00
SUBTOTAL III.	2.18	27.53%	NA	NA	$168,891.54	$18,000.00
GRAND TOTAL ALL AREAS	7.92	100.00%	NA	NA	$612,861.00	$30,400.00

SUMMARY FOR RO (Enter I - X):	V				REPORTING QUARTER OF FY 2006 (Enter 1-4):	4
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO V =	Percent of Total FTEs RO V	Number Of Activities Completed RO V	FTE Per Activity RO V	Personnel Cost Per Activity* TOTAL for RO V	Travel Cost Per Activity TOTAL for RO V
	10.00				$854,000.00	$22,248.85
I. FRONT-END FINANCIAL MANAGEMENT					(Qtr 4 Only)	
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.52	5.19%	46	0.01	$44,315.67	$22.05
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.34	3.39%	5	0.07	$28,954.90	$620.55
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.20	1.97%	5	0.04	$18,826.24	$257.25
4. Financial Administrative Policy Technical Assistance	0.22	2.15%	137	0.00	$18,369.08	$807.95
SUBTOTAL I.A.	1.27	12.70%	192	NA	$108,465.89	$1,507.80
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.79	7.89%	37	0.02	$67,402.24	$857.36
8. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.39	3.85%	30	0.01	$32,910.24	$268.80
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.28	2.81%	9	0.03	$22,287.32	$1,231.77
8. Financial Program Policy Technical Assistance	0.42	4.17%	125	0.00	$35,822.32	$701.40
SUBTOTAL I.B.	1.85	18.53%	201	NA	$158,222.13	$3,059.32
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	1.51	15.05%	15	0.10	$128,539.89	$4,445.46
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.20	1.98%	6	0.03	$18,871.71	$23.10
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.72	7.19%	31	0.02	$61,405.16	$60.90
12. Deferrals and Disallowances	0.89	8.87%	31	0.03	$75,717.19	$1,207.50
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.72	7.22%	133	0.01	$61,648.22	$2,146.25
SUBTOTAL II.	4.03	40.30%	218	NA	$344,182.16	$7,883.21
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	1.90	18.98%	48	0.04	$182,077.52	$7,948.22
B. Desk Reviews in Regional Office	0.44	4.40%	0	na	$37,610.05	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.38	3.83%	48	0.01	$32,701.95	$1,850.10
B. Desk Reviews in Regional Office	0.13	1.26%	0	na	$10,740.29	$0.00
SUBTOTAL III.	2.85	28.47%	96	NA	$243,129.82	$9,798.32
GRAND TOTAL ALL AREAS	10.00	100.00%	705	NA	$854,000.00	$22,248.65

* Report Total Personnel Costs in Cell F7 for Entire Fiscal Year Only in Quarter 4 RO FMWR

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005						
REGION (ENTER I - X):	VI					SUMMARY FOR RO VI
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO VI =	Percent of Total FTEs RO VI	Number Of Activities Completed RO VI	FTE Per Activity RO VI	Personnel Cost Per Activity TOTAL for RO VI	Travel Cost Per Activity TOTAL for RO VI
	6.00				$481,645.00	$33,219.00
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.50	8.33%	15	0.03	$40,137.08	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.25	4.17%	5	0.05	$20,068.54	$0.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.00	0.00%	0	na	na	$0.00
4. Financial Administrative Policy Technical Assistance	0.40	6.67%	100	0.00	$32,109.67	$0.00
SUBTOTAL I.A.	1.15	19.17%	NA	NA	$92,315.29	$0.00
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.20	3.33%	50	0.00	$16,054.83	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.20	3.33%	3	0.07	$16,054.83	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.10	1.67%	20	0.01	$8,027.42	$0.00
8. Financial Program Policy Technical Assistance	0.50	8.33%	100	0.01	$40,137.08	$0.00
SUBTOTAL I.B.	1.00	16.67%	NA	NA	$80,274.17	$0.00
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	1.00	16.67%	5	0.20	$80,274.17	$15,000.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.20	3.33%	10	0.02	$16,054.83	$0.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.25	4.17%	15	0.02	$20,068.54	$0.00
12. Deferrals and Disallowances	0.45	7.50%	10	0.05	$36,123.38	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.20	3.33%	75	0.00	$16,054.83	$0.00
SUBTOTAL II.	2.10	35.00%	NA	NA	$168,575.75	$15,000.00
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	0.95	15.83%	21	0.05	$76,260.46	$9,110.00
B. Desk Reviews in Regional Office	0.45	7.50%	3	0.15	$36,123.38	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.25	4.17%	21	0.01	$20,068.54	$9,109.00
B. Desk Reviews in Regional Office	0.10	1.67%	3	0.03	$8,027.42	$0.00
SUBTOTAL III.	1.75	29.17%	NA	NA	$140,479.79	$18,219.00
GRAND TOTAL ALL AREAS	6.00	100.00%	NA	NA	$481,645.00	$33,219.00

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005						
REGION (ENTER I - X):	VII					SUMMARY FOR RO VII
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO VII =	Percent of Total FTEs RO VII	Number Of Activities Completed RO VII	FTE Per Activity RO VII	Personnel Cost Per Activity TOTAL for RO VII	Travel Cost Per Activity TOTAL for RO VII
	5.00				$368,447.00	$16,199.00
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.10	2.00%	0	na	$7,328.94	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.05	1.00%	0	na	$3,664.47	$0.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.00	0.00%	0	na	na	$0.00
4. Financial Administrative Policy Technical Assistance	0.10	2.00%	0	na	$7,328.94	$0.00
SUBTOTAL I.A.	0.25	5.00%	NA	NA	$18,322.35	$0.00
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.00	0.00%	0	na	na	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.00	0.00%	0	na	na	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.00	0.00%	0	na	na	$0.00
8. Financial Program Policy Technical Assistance	0.10	2.00%	0	na	$7,328.94	$0.00
SUBTOTAL I.B.	0.10	2.00%	NA	NA	$7,328.94	$0.00
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	1.70	34.00%	0	na	$124,591.98	$3,857.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.00	0.00%	0	na	na	$0.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.50	10.00%	0	na	$36,644.70	$0.00
12. Deferrals and Disallowances	0.40	8.00%	0	na	$29,315.76	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.10	2.00%	0	na	$7,328.94	$0.00
SUBTOTAL II.	2.70	54.00%	NA	NA	$197,881.38	$3,857.00
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	1.70	34.00%	0	na	$124,591.98	$12,342.00
B. Desk Reviews In Regional Office	0.00	0.00%	0	na	na	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.00	0.00%	0	na	na	$0.00
B. Desk Reviews In Regional Office	0.25	5.00%	0	na	$18,322.35	$0.00
SUBTOTAL III.	1.95	39.00%	NA	NA	$142,914.33	$12,342.00
GRAND TOTAL ALL AREAS	5.00	100.00%	NA	NA	$366,447.00	$16,199.00

SUMMARY FOR RO (Enter I - X):	VIII	RTERLY RO FINANCIAL MANAGEMENT WORKPLAN REPORT (RO FMWR) FOR FY:				4
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO VIII =	Percent of Total FTEs RO VIII	Number Of Activities Completed RO VIII	FTE Per Activity RO VIII	Personnel Cost Per Activity* TOTAL for RO VIII	Travel Cost Per Activity TOTAL for RO VIII
	2.75				$251,056.00	$11,900.00
I. FRONT-END FINANCIAL MANAGEMENT					(Qtr 4 Only)	
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.14	5.09%	7	0.02	$12,626.95	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.04	1.45%	1	0.04	$3,664.84	$0.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.00	0.00%	0	NA	NA	$0.00
4. Financial Administrative Policy Technical Assistance	0.06	2.18%	60	0.00	$5,497.27	$0.00
SUBTOTAL I.A.	0.24	8.73%	NA	NA	$21,989.06	$0.00
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.00	0.00%	0	NA	NA	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.04	1.45%	20	0.00	$3,664.64	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.10	3.64%	11	0.01	$9,162.11	$0.00
8. Financial Program Policy Technical Assistance	0.31	11.27%	220	0.00	$26,402.54	$0.00
SUBTOTAL I.B.	0.45	16.36%	NA	NA	$41,229.49	$0.00
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	0.73	26.55%	3	0.24	$66,883.40	$6,000.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.09	3.27%	0	NA	$6,245.90	$0.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.08	2.91%	6	0.01	$7,329.69	$0.00
12. Deferrals and Disallowances	0.18	6.55%	9	0.02	$16,491.60	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.10	3.64%	71	0.00	$9,162.11	$0.00
SUBTOTAL II.	1.18	42.91%	NA	NA	$108,112.89	$6,000.00
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	0.16	5.82%	7	0.02	$14,659.37	$5,900.00
B. Desk Reviews in Regional Office	0.65	23.64%	41	0.02	$59,553.71	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.00	0.00%	0	NA	NA	$0.00
B. Desk Reviews in Regional Office	0.07	2.55%	46	0.00	$6,413.46	$0.00
SUBTOTAL III.	0.88	32.00%	NA	NA	$60,626.56	$5,900.00
GRAND TOTAL ALL AREAS	2.75	100.00%	NA	NA	$251,950.00	$11,900.00

* Report Total Personnel Costs in Cell F7 for Entire Fiscal Year Only in Quarter 4 RO FMWR

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005						
Region (Enter I - X):	IX					SUMMARY FOR RO IX
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO IX =	Percent of Total FTEs RO IX	Number Of Activities Completed RO IX	FTE Per Activity RO IX	Personnel Cost Per Activity TOTAL for RO IX	Travel Cost Per Activity TOTAL for RO IX
	8.00				$540,000.00	$21,100.00
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.18	3.00%	12	0.02	$16,200.00	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.18	2.87%	12	0.01	$14,400.00	$0.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.08	1.00%	8	0.01	$5,400.00	$0.00
4. Financial Administrative Policy Technical Assistance	0.52	8.87%	238	0.00	$46,800.00	$0.00
SUBTOTAL I.A.	0.92	15.33%	NA	NA	$82,800.00	$0.00
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.23	3.83%	17	0.01	$20,700.00	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.20	3.33%	15	0.01	$18,000.00	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.34	5.67%	15	0.02	$30,600.00	$0.00
8. Financial Program Policy Technical Assistance	0.64	10.67%	270	0.00	$57,600.00	$0.00
SUBTOTAL I.B.	1.41	23.50%	NA	NA	$126,900.00	$0.00
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	0.47	7.83%	6	0.08	$42,300.00	$9,300.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.26	4.33%	5	0.05	$23,400.00	$0.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.22	3.67%	31	0.01	$19,800.00	$0.00
12. Deferrals and Disallowances	0.15	2.50%	25	0.01	$13,500.00	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.25	4.17%	57	0.00	$22,500.00	$0.00
SUBTOTAL II.	1.35	22.50%	NA	NA	$121,500.00	$9,300.00
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	0.77	12.83%	14	0.06	$69,300.00	$11,800.00
B. Desk Reviews in Regional Office	0.98	18.33%	44	0.02	$88,200.00	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.10	1.67%	4	0.03	$9,000.00	$0.00
B. Desk Reviews in Regional Office	0.47	7.83%	35	0.01	$42,300.00	$0.00
SUBTOTAL III.	2.32	38.67%	NA	NA	$208,800.00	$11,800.00
GRAND TOTAL ALL AREAS	8.00	100.00%	NA	NA	$540,000.00	$21,100.00

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005						
REGION (ENTER I - X):	X					SUMMARY FOR RO X
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO X =	Percent of Total FTEs RO X	Number Of Activities Completed RO X	FTE Per Activity RO X	Personnel Cost Per Activity TOTAL for RO X	Travel Cost Per Activity TOTAL for RO X
	5.00				$398,238.00	$41,000.00
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.15	3.00%	4	0.04	$11,947.14	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.10	2.00%	4	0.03	$7,964.76	$1,000.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.30	6.00%	85	0.00	$23,894.28	$6,000.00
4. Financial Administrative Policy Technical Assistance	0.15	3.00%	65	0.00	$11,947.14	$0.00
SUBTOTAL I.A.	0.70	14.00%	NA	NA	$55,753.32	$7,000.00
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.25	5.00%	55	0.00	$19,911.90	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.50	10.00%	12	0.04	$39,823.80	$2,000.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.10	2.00%	30	0.00	$7,964.76	$3,000.00
8. Financial Program Policy Technical Assistance	0.15	3.00%	80	0.00	$11,947.14	$0.00
SUBTOTAL I.B.	1.00	20.00%	NA	NA	$79,647.80	$5,000.00
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	0.50	10.00%	5	0.10	$39,823.80	$8,000.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.10	2.00%	6	0.02	$7,964.76	$0.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.50	10.00%	12	0.04	$39,823.80	$4,500.00
12. Deferrals and Disallowances	0.40	8.00%	8	0.05	$31,859.04	$1,000.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.50	10.00%	80	0.01	$39,823.80	$0.00
SUBTOTAL II.	2.00	40.00%	NA	NA	$159,295.20	$13,500.00
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	1.00	20.00%	16	0.06	$79,647.60	$10,600.00
B. Desk Reviews In Regional Office	0.00	0.00%	0	na	na	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.30	6.00%	16	0.02	$23,894.28	$4,900.00
B. Desk Reviews In Regional Office	0.00	0.00%	0	na	na	$0.00
SUBTOTAL III.	1.30	26.00%	NA	NA	$103,541.88	$15,500.00
GRAND TOTAL ALL AREAS	5.00	100.00%	NA	NA	$398,238.00	$41,000.00

Question 4:

One of the President's proposals would require all payments to public hospitals and nursing homes to be limited to the cost of the services provided. That sounds reasonable and we should be prudent in spending Medicaid's precious resources. But this proposal ignores the fact that other payers, Medicare and private insurance are not limited in the same way. Why should we be treating Medicaid differently? Wouldn't requiring Medicaid to pay even less than it already does have an adverse impact on access to quality hospital and nursing home care for Medicaid beneficiaries?

Answer:

Currently, payments to individual state and local government providers are not limited to the amount it actually costs to provide services to Medicaid patients. Instead, the upper payment limits to these providers are governed by regulations defining the Medicaid Upper Payment Limit (UPL). These regulations limit what Medicaid will pay for services to a reasonable estimate of what Medicare would have paid for similar services. States have maximized Federal matching payments by claiming expenditures that far exceed their actual costs of providing a service and through various recycling arrangements have shifted costs to the Federal government.

The Federal government should limit its contribution to the amount of providing its share of the cost of providing services to Medicaid beneficiaries. Other health insurance payers limit the payments made on behalf of their covered lives to the costs of providing care to those individuals; Medicaid should do the same. The General Accountability Office (GAO) has repeatedly recommended that "Congress should consider implementing a recommendation…to enact legislation to prohibit Medicaid payments that exceed costs to any government-owned facility."[1]

The Administration proposes to amend the Social Security Act to provide that Medicaid federal financial participation, or FFP, would not be available for state payments made to state or non-state government-owned or operated facilities or providers which exceed a facility's or provider's actual costs of providing such assistance. For purposes of determining cost, Medicare reasonable cost payment principles would apply. Cost-based payment limits would be applied on an individual, facility-specific basis to state-owned and non-state owned government providers for services provided, including inpatient hospital services, outpatient hospital services, nursing facility services, ICF-MRs, clinics, physicians, schools, home and community based waivers, etc. The cost-based payment limit would replace current regulatory upper payment limits that affect state or non-state government providers. Limits are service based by facility as determined by using Medicare principles of reimbursement.

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[1] Allen, Kathryn. "Medicaid: State Financing Schemes Again Drive Up Federal Payments." GAO testimony presented to the U.S. Senate Committee on Finance. September 6, 2000. See also "Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government." GAO/HEHS-94-133, August 1, 1994.

Question 5:

CMS has clearly made strides in its enforcement of its new IGT policies. According to the chart you submitted to members of Congress in May, there are only ten states that you identified as having a potential violation. Now, that number may be lower because two of the states (California and Iowa) recently announced agreements with CMS that appear to reform their IGT arrangements, and I understand one state (North Dakota) should not appear on that list.

a. **Given CMS' significant work in this area already, do you believe legislation is needed?**

b. **As you know, CBO has said that it would be difficult to realize significant scorable savings in this area. If Congress were to pass legislation to reform IGT policy, would you envision that the full $5 billion of proposed savings in the President's policy would come from the remaining eight states that are in potential violation of CMS' policy?**

Answer:

(a) Yes. Legislation is necessary to codify existing statutory and regulatory requirements into an express provision prohibiting recycling mechanisms. As currently constructed, the statute contains numerous provisions, which taken together, prohibit recycling. However, an express statutory prohibition would consolidate in one place current policy and law.

(b) We believe the scoring would remain the same as it would prevent all states from implementing new recycling arrangements. In addition, the remaining states yet to terminate recycling arrangements would also be accounted for in the scoring.

Question 6:

The Medicaid statute restricts states' ability to impose cost-sharing above a nominal amount and prohibits it for pregnant women and children. CMS has waived Medicaid's cost-sharing restrictions in a number of states even though it is unclear whether the Secretary has the statutory authority to do so. A number of studies, ranging from the RAND health experiment study in the 1970s to the Kaiser Family Foundation study of Oregon's experience with premiums, indicate that increased cost-sharing can have an adverse effect on health outcomes and can increase emergency room use. Given these findings, what is CMS' rationale for allowing increased cost-sharing in Medicaid? What steps, if any, has CMS taken to document the effect of increasing cost-sharing for the states that have waived cost-sharing restrictions? What does your data indicate about the actual impact of cost-sharing on health quality and costs?

Answer:

The Secretary has not waived any cost sharing restrictions for individuals who are eligible under an approved State plan, consistent with the statutory provisions as section 1916(f) of the Social Security Act. But states are not required to follow Medicaid cost sharing restrictions when expanding coverage to groups outside the scope of the approved State plan.

Providing states with cost sharing flexibility has allowed states to expand covered populations, promote patient responsibility and direct appropriate utilization of services that result in program cost savings.

Recent Medicaid program studies and evaluations have demonstrated that cost sharing is not a barrier to access and that beneficiaries are satisfied with state cost-sharing requirements. Examples are:

- A 2004 North Dakota Medicaid Customer Service Survey of 3,213 Medicaid Recipients reported that for an overall 93 percent of responded cost sharing was not a barrier to receiving needed medical care.
- A 2004 Institute for Child Health Policy analysis of Florida's SCHIP program survey showed that 86% of families feel that the premium amount is "about right" and 75 percent of families reported rarely or never had difficulty paying premium. Ninety-seven percent of families agreed with the statement that they felt good about paying for part of their children's health care coverage.
- A 2003 CMS sponsored evaluation of Wisconsin's Badger Care Demonstration program found that 84% of families that paid premiums (>150%-200% FPL) considered the premiums reasonable and did not seem to be a significant burden to the majority of premium paying families.

CMS now requires as part of any demonstration program terms and conditions that key program components must be evaluated and this would include an evaluation of any cost-sharing provisions.

Question 7:

Recently California announced it had gotten approval for a waiver from CMS that would require public hospitals to submit certified public expenditures (CPEs) as a means of getting federal reimbursement for their share of Medicaid funding. Can you explain how a CPE differs from an IGT? I have heard that public hospitals are concerned about the uncertainty of reimbursement when they submit a CPE – either from federal or state agencies. Is this a legitimate concern? What additional protections against fraud would CPEs provide?

Answer:

(1) Under Medicaid law, allowable certified public expenditures (CPEs) and allowable intergovernmental transfers (IGTs) are methods, which the statute and regulations permit, that allow states to share the non-federal share of their Medicaid program with local governments. An allowable IGT occurs when a state or local unit of government (including governmental healthcare providers) transfers funds derived from state or local taxes within the state to the state Medicaid agency to be used as the non-federal share of state Medicaid expenditures. An allowable CPE occurs when a state or local unit of government (including governmental healthcare providers) certify to the state that they have incurred Medicaid expenditures that are eligible for Federal matching. Thus, an IGT is an actual transfer of funds to the state, while a CPE is simply a certification that government funds were expended to provide services to populations eligible under Title XIX.

(2) No. Under California's 1115 waiver authority, reimbursement to governmentally-operated hospitals will be based on all allowable Medicaid inpatient hospital costs as authorized under terms and conditions of the State's 1115 demonstration. The allowable costs will be derived from the most recently audited Medicare 2552-96 cost report as audited by the fiscal intermediary (FI) for purposes of Medicare reimbursement. Interim and final reconciliation will be based on filed and audited Medicare 2552-96 cost reports respectively.

(3) We believe that determining Medicaid reimbursements through the use of the most recently audited Medicare 2552-96 cost report as audited by the fiscal intermediary for purposes of Medicare reimbursement provides protection against the overstatement of Medicaid costs.

Question 8:

You testified about the work CMS is now doing in the Medi-Medi program to improve its tracking of fraud and abuse. Could you provide more information about the program and its experience? Specifically, please share any templates of a scope of work (SOW) and computer matching agreement (CMA) that expansion states could use (as described on p. 20) and any tracking reports being used in California and six expansion states that show cost avoidances, savings, and recoveries (p. 21, very top of page)? Could you also share any of the most recent tracking reports for these projects?

Answer:

See:

Attachment A – Computer Matching Agreement Between the Centers for Medicare & Medicaid Services and the State of Florida Agency for Health Care Administration for Disclosure of Medicare and Medicaid Information

Attachment B – Exhibit I: Florida Medicare/Medicaid Data Analysis Center SOW

Attachment C – FY 2005 1st Quarter Report on Medicare/Medicaid Data-Match (Medi-Medi) Projects

Attachment D – FY 2005 2nd Quarter Report on Medicare/Medicaid Data-Match (Medi-Medi) Projects

Attachment A

COMPUTER MATCHING AGREEMENT
BETWEEN THE
CENTERS FOR MEDICARE & MEDICAID SERVICES
AND
THE STATE OF FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION FOR DISCLOSURE OF MEDICARE AND MEDICAID INFORMATION

Computer Matching Program (Match No. 2003-03)

I. PURPOSE, LEGAL AUTHORITY, AND DEFINITIONS

A. Purpose

The purpose of this agreement is to establish the conditions, safeguards, and procedures under which the Centers for Medicare & Medicaid Services (CMS) will conduct a computer matching program with the State of Florida Agency for Health Care Administration (AHCA) to study claims, billing, and eligibility information to detect suspected instances of Medicare and Medicaid fraud and abuse (F&A) in the State of Florida. CMS and AHCA will provide TriCenturion, a CMS contractor (hereinafter referred to as the "Custodian") with Medicare and Medicaid records pertaining to eligibility, claims, and billing which the Custodian will match in order to merge the information into a single database. Utilizing fraud detection software, the information will then be used to identify patterns of aberrant practices requiring further investigation. The following are examples of the type of aberrant practices that may constitute F&A by practitioners, providers, and suppliers in the State of Florida expected to be identified in this matching program: (1) billing for provisions of more than 24 hours of services in one day, (2) providing treatment and services in ways more statistically significant than similar practitioner groups, and (3) up-coding and billing for services more expensive than those actually performed.

B. Legal Authority

This agreement is executed to comply with the Privacy Act of 1974 (Title 5 United States Code (U.S.C.) § 552a), (as amended by Public Law (Pub. L.) 100-503, the Computer Matching and Privacy Protection Act (CMPPA) of 1988), the Office of Management and Budget (OMB) Circular A-130, titled "Management of Federal Information Resources" at 65 *Federal Register* (Fed. Reg.) 77677 (December 12, 2000), and OMB guidelines pertaining to computer matching at 54 Fed. Reg. 25818 (June 19, 1989).

This agreement provides for information matching fully consistent with the authority of the Secretary of the Department of Health and Human Services (Secretary). Section 1816 of the Social Security Act (the Act) permits the Secretary to contract with fiscal intermediaries to "make such audits of the records of providers as may be necessary to insure that proper payments are made under this part," and to "perform such other functions as are necessary to carry out this subsection" (42 U.S.C. § 1395h (a)).

Section 1842 of the Act provides that the Secretary may contract with entities known as carriers to "make such audits of the records of providers of services as may be necessary to assure that proper payments are made" (42 U.S.C. § 1395u(a)(1)(C)); "assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits" (42 U.S.C. § 1395u(a)(2)(B)); and "to otherwise assist . . . in discharging administrative duties necessary to carry out the purposes of this part" (42 U.S.C. § 1395u(a)(4)).

Furthermore, §1874(b) of the Act authorizes the Secretary to contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this title (42 U.S.C. § 1395kk(b)).

Section 1893 of the Act establishes the Medicare Integrity Program, under which the Secretary may contract with eligible entities to conduct a variety of program safeguard activities, including fraud review employing equipment and software technologies that surpass the existing capabilities of Fiscal Intermediaries and carriers (42 U.S.C. § 1395ddd)). The contracting entities are called Program Safeguards Contractors (PSC).

Pursuant to § 409.902, Florida Statutes (F.S.), AHCA is charged with the administration of the Medicaid program in Florida, and is the single state agency for such purpose. AHCA is required to operate a program to oversee the activities of Florida Medicaid recipients and providers to ensure that fraudulent and abusive behavior occurs to the minimum extent possible (§ 409.913, F.S.).

AHCA's disclosure of the Medicaid data pursuant to this agreement is for purposes directly connected with the administration of the Medicaid program, in compliance with 42 CFR 431.300 through 431.307. Those purposes are the detection, prosecution and deterrence of F&A in the Medicaid program.

C. Definitions

For purposes of this agreement, the following definitions apply:

1. "the Act" means the Social Security Act;

2. Computer match contract" means the contract between CMS and the Custodian for data matching and related functions which this agreement contemplates and facilitates;

3. "CMS" means the Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration;
4. "Custodian" means the Medicare Integrity Program (MIP) entity with which CMS is contracting to perform the data matching and related functions described in this Agreement;
5. "AHCA" means the State of Florida Agency for Health Care Administration;
6. "HHS" means the United States Department of Health and Human Services;
7. "F&A" means health care fraud and abuse;
8. "Medicare" means the health insurance program established under Title XVIII of the Act;
9. "Recipient agency," as defined by the Privacy Act (5 U.S.C. § 552a (a)(9)), means the agency receiving the records and actually performing the computer match; i.e., the matching agency, CMS;
10. "Source agency," as defined by the Privacy Act (5 U.S.C. § 552a (a)(11)), means the agency initially disclosing the records for the purpose of the match; i.e., AHCA;
11. "Florida Medicaid Program" means the Medicaid program established under Title XIX of the Act, together with other health care programs established under Florida law.

II. DESCRIPTION OF THE MATCH

The information provided by CMS and AHCA will be used in a computer-matching program that will produce matched data on claims and eligibility in the Federal Medicare and the Florida Medicaid programs. Linking elements of both programs that identify Medicare beneficiaries and Medicaid recipients as well as providers who are common to both programs will carry out the matching of CMS and AHCA data. In addition to the provider and beneficiary/recipient identifiers, the match will include claim data elements identifying services, procedures, diagnostic, and other related information that may permit detection of F&A in either of the two programs. The matching program described herein will be conducted via sophisticated fraud detection software that identifies patterns and deviations therefrom, in data sets to identify potential fraud or abuse. As such, the software may match any or all fields in one record against any or all fields in one or more other records. Because of the impossibility of precisely identifying beforehand all possible matching combinations, this agreement instead sets forth in Attachment 9, a list of all data elements contained in the Medicare and Medicaid records subject to matching.

This computer matching operation will enhance the ability of CMS and AHCA to detect F&A, as well as potential overpayments to practitioners, providers, and suppliers in both the Medicare and Florida Medicaid programs. Combining claims and eligibility data from multiple health programs provides a more complete picture of beneficiary care and provider practices than can be gained by analyzing data from one program in isolation, and likely will reveal patterns of F&A undetectable from analysis of data from any one particular program. This premise will be thoroughly evaluated in conducting this match, and to ensure adequate program evaluation, all Florida Medicaid related reports created by the Custodian pursuant to the match will be provided to AHCA at the same time as they are provided to CMS.

Cases of potential F&A will be detected through data analysis. Cases of potential F&A in the Medicare program will be more fully developed, and referred to entities that may include the Medicare Carrier, Medicare Fiscal Intermediary, and/or law enforcement agencies including the HHS' Office of Inspector General and the Department of Justice. Cases of potential F&A in the Florida Medicaid program detected by the match will be more fully developed by AHCA, in part from direct access to the matched data involving Medicaid and other applications used to access matched data, and acted upon or referred by AHCA to appropriate state authorities including the Florida Attorney General's Medicaid Fraud Control Unit. Cases of potential F&A that involve both the Medicare and Florida Medicaid programs will be developed under the direction of both CMS and AHCA and may be referred for further action, as appropriate, by CMS and/or AHCA to some or all of the entities described above.

III. JUSTIFICATION AND ANTICIPATED RESULTS

A. Justification

In 2000, Medicare program losses due to F&A, honest mistakes, and claims payment problems totaled approximately $13.5 billion. A recent report by the General Accounting Office (GAO) states that "Medicaid is at risk for billions of dollars in improper payments." (GAO, "Medicaid—State Efforts to Control Improper Payments Vary," July 10, 2001). Consolidated access to both Medicare and Medicaid data offers a good perspective on the complete picture of a beneficiary's total care, as well as each health care provider's entire practice. Such access will enable CMS and AHCA to apply tools and technology to look for a wide range of potential F&A that can best, or only, be found by combining the data from the utilization of benefits across both programs. For example, this type of analysis will enhance the ability to identify providers "flying below the radar screen" because their actions in one program do not arouse suspicion, but where an abberrance become manifest upon analyzing data culled from more than one program. Medicare and the Florida Medicaid program will benefit from this data matching with the identification, research, development, and referral of F&A cases to law enforcement for action and possible recoupment of Medicare and Medicaid funds.

B. Anticipated Results

The matching program is expected to reveal evidence of an aberrance such as over-utilization of services or overbilling, for example, providers billing for more services than reasonably could be performed during the course of one day. CMS anticipates that this matching program will yield a return on investment at least on par with previous program integrity efforts. From fiscal years 1988 through 1996, program integrity return on investment ranged from 11:1 to 16:1, averaging about 14:1. In layman's terms, every $1 spent on program integrity efforts yielded an average of $14 in savings.

CMS also anticipates that the act of undertaking this effort and providing the requisite notice will have a sentinel effect likely to change the behavior of providers or beneficiaries inclined to commit F&A. CMS justifies this with survey data that suggests that Americans believe that health care fraud is widespread and not adequately being addressed. For example, a poll of 2000 adults of all ages released in February 1999 by the American Association of Retired Persons revealed that about 80 percent thought healthcare fraud was either somewhat or extremely widespread, while "[n]early eight in 10 said they were unaware of any efforts to reduce the problem." (CNN.com, "Federal Campaign Enlists Seniors as Medicare 'Fraud Busters,'" Feb 24, 1999).

IV. DESCRIPTION OF RECORDS

A. The data for CMS are maintained in the following Systems of Records (SOR):

1. National Claims History (NCH), System No. 09-70-0005 was most recently published in the *Federal Register*, at 67 Fed. Reg. 57015 (September 6, 2002.) NCH contains records needed to facilitate obtaining Medicare utilization review data that can be used to study the operation and effectiveness of the Medicare program. Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice. (A copy of the system notice is given as Attachment 1).

2. Carrier Medicare Claims Record, System No. 09-70-0501 published in the *Federal Register* at 67 Fed. Reg. 54428 (August 22, 2002). Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice. (A copy of the system notice is given as Attachment 2).

3. Enrollment Database, System No. 09-70-0502 (formerly known as the Health Insurance Master Record) published at 67 Fed. Reg. 3203 (January 23, 2002). Matched data will be released to AHCA pursuant to the routine use set forth in the system notice. (A copy of the system notice is given as Attachment 3).

4. Intermediary Medicare Claims Record, System No. 09-70-0503 published in the *Federal Register* at 67 Fed. Reg. 65982 (October 29, 2002). Matched data will be

released to AHCA pursuant to the routine use as set forth in the system notice. (A copy of the system notice is given as Attachment 4).

5. Unique Physician/Provider Identification Number (formerly known as the Medicare Physician Identification and Eligibility System), System No. 09-70-0525, was most recently published in the *Federal Register* at 53 Fed. Reg. 50584 (December 16, 1988). Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice. (A copy of the system notice is given as Attachment 5).

6. Medicare Supplier Identification File, System No. 09-70-0530 was most recently published in the *Federal Register*, at 67 Fed. Reg. 48184 (July 23, 2002). Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice. (A copy of the system notice is given as Attachment 6).

7. Medicare Beneficiary Database, System No. 09-70-0536 published in the *Federal Register* at 67 Fed. Reg. 63392 (December 6, 2001). Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice. (A copy of the system notice is given as Attachment 7).

B. The data for AHCA that will be made available for the matching program described herein are maintained in the following data files:

Daily Claims History File
Current Month End File
Procedure Drug and Diagnosis File
Provider Charge File
Recipient File
Provider File
Department of Health (Prescribing Physician's License File)

All or part of these files may be used in this data-matching program. (A sample of the file layouts is given in Attachment 8).

C. Number of Records Involved

1. Medicare records will include the entire body of Medicare data for all eligible beneficiaries residing in Florida. Medicare records will be matched against the records of all Florida Medicaid recipients. There are approximately 2.1 million Medicaid recipients in Florida generating approximately 78 to 104 million claims and encounters per year, and approximately 2.3 million Medicare beneficiaries residing in Florida generating approximately 90 million claims per year.

2. CMS will provide the Custodian with access to claims and eligibility data for the Medicare program updated on a monthly basis. Three to 3 years worth of data are

accessible at any given time. Older data will be purged as newer data loads become available.

3. AHCA will provide the Custodian with access to current Medicaid claims and eligibility data specified in Section IV.B with updates on a monthly basis. There are currently 36 months worth of data available at any given time. The Custodian, by using monthly data loads and purges of older data, will be able to maintain approximately 3 years of Medicaid data for F&A analysis.

D. Data Elements in the Match

See Attachment 9 for a sample record formats and/or data elements for the finder file and the reply file.

E. Starting and Completion Dates

The matching program, which will be conducted by the Custodian, will occur continually from a date beginning after the Congressional/OMB review and public comment requirements, mandated by the Privacy Act, have been satisfied, and ending upon the final expiration of this computer matching agreement, unless terminated sooner by reason of abrogation of the computer match contract.

V. NOTICE PROCEDURES

Both providers/suppliers and beneficiaries will be notified via the *Federal Register* of this particular data-matching program. Moreover, consistent with the requirements of 5 U.S.C. § 552a(o)(1)(D), Medicare eligible, provider/supplier applicants, Medicare beneficiaries, and enrolled providers/suppliers are repeatedly made aware that "any information provided by such applicants, recipients, holders and individuals may be subject to verification through matching programs." Similarly, providers/suppliers and beneficiaries are repeatedly made aware of their obligations with respect to maintaining the integrity of the Medicare program, and that violators may face criminal conviction or civil penalty. Examples of both types of notice are provided below.

Individuals who are Medicare eligible, as part of the enrollment process, are informed via CMS Form 250 that they "should be aware the Public Law 100-503, the Computer Matching and Privacy Protection Act of 1988 (CMPPA), amended the Privacy Act, 5 U.S.C. § 552a, permits the government to verify information by way of computer matches."

CMS 1500 claim forms carry a Privacy Act statement as a notice to patients that states, among other things, that the CMPPA, permits the government to verify information by way of computer matches." In addition, CMS notifies beneficiaries annually of matching activities by way of the Social Security Benefits Statement (SSA-1099 form).

As part of the enrollment process, Medicare providers/suppliers that have been identified on one of the five applications in a series titled, "Medicare Federal Health Care Provider/Supplier Enrollment Applications" (CMS Form(s) 855A, 855B, 855I, 855R, and 855S) are notified that "[t]he applicant should be aware that the CMPPA permits the government to verify information through computer matching." Likewise, this form advises providers/suppliers of the penalties for falsifying information on the enrollment application.

Beneficiary enrollment forms used by the Florida Medicaid program give notice that applicants' information is subject to verification through data sharing with other state and Federal agencies. The Florida Medicaid Provider General Handbook states that information submitted by providers is subject to review, investigation, analysis, audit, or any combination thereof, by AHCA or its contractors to determine possible fraud, abuse, overpayment, or beneficiary neglect in the Medicaid program. (Examples of the beneficiary form and the provider handbook are shown as Attachment 10)

VI. VERIFICATION PROCEDURES

Suspected fraud or abuse cases, as well as other cases of apparent overpayment, will primarily be developed against providers and/or suppliers of Medicare and Medicaid services. It is not believed likely, but it cannot be excluded as a possibility, that the computer matching process may find instances of suspected beneficiary involvement in fraud, waste, or abuse scheme(s). Except where clearly suspect activity warrants immediate referral to law enforcement authorities, cases of suspected fraud or abuse will be developed through analysis of the combined claims utilization data, and verified through reviews of medical records requested from the provider/supplier, prior to referral to law enforcement.

AHCA shall be responsible for such reviews in cases with potential impact only on Medicaid. For cases involving potential impact on both Medicaid and Medicare, CMS and AHCA will work cooperatively to develop and verify the cases before referrals to law enforcement are made. Potential overpayments will be thoroughly verified through data analysis and medical record review prior to any collection efforts. Procedures enabling providers/suppliers to rebut overpayment findings are found at 42 CFR 405.374.

VII. RETENTION AND DESTRUCTION OF IDENTIFIABLE RECORDS

Neither CMS nor AHCA will create a separate electronic file or SOR consisting of only individuals whose records were selected in this matching program nor otherwise have ownership or control of the other's records made accessible to each by the Custodian. However, as a result of this project, files will be created based on this data to support recovery of overpayments, or to pursue investigation and possible prosecution of fraud, waste, and abuse cases. These files will be destroyed in a manner consistent with the destruction of other, similar files, created via other means. Other than files created for the aforementioned purposes, CMS and AHCA will retain all identifiable records received from the data matching program only for the period of time required for the period of performance related to the data matching program, and will then destroy the records. Older data will be deleted, as new data becomes available. Magnetic tape files shall be erased. Electronic data shall be deleted. A letter indicating that CMS's identifiable data has been destroyed must be submitted by AHCA to CMS, along with any other pertinent information.

CMS and the Custodian shall maintain, acquire, use and disclose all Florida Medicaid data provided by AHCA under this agreement in compliance with Federal and state laws and regulations governing such information, including but not limited to 42 U.S.C. § 1394a(a)(7), 42 CFR Part 431.300 et seq., Florida Human Resources Code §§ 12.003 & 21.012; and Florida Government Code Chapter 552. This responsibility includes treating all Medicaid recipient data provided by AHCA as confidential. CMS shall provide AHCA with a list of personnel authorized to access the Florida Medicaid data.

VIII. SECURITY PROCEDURES

A. CMS and AHCA agree to safeguard data received from the each other as follows:

1. Access to the records matched and to any records created by the match will be restricted to only those authorized employees and officials who need them to perform their official duties in connection with the uses of the information authorized in this Agreement. Further, all personnel who will have access to the records matched and to any records created by the match will be advised of the confidential nature of the information, the safeguards required to protect the records and the civil and criminal sanctions for noncompliance contained in applicable Federal laws.

2. The records matched and any records created by the match will be stored in an area that is physically safe from access by unauthorized persons during duty hours as well as non-duty hours or when not in use.

3. The records matched, and any records created by the match, will be processed under the immediate supervision and control of authorized personnel, to protect the confidentiality of the records in such a way that unauthorized persons cannot retrieve any such records by means of computer, remote terminal or other means.

4. The records matched and records created by the match will be transported under appropriate safeguards.

5. CMS may make onsite inspections, and may make other provisions to ensure that AHCA and the Custodian are maintaining adequate safeguards.

B. CMS and ACHA shall also adopt policies and procedures to ensure that information contained in their respective records shall be used solely as provided in this agreement.

C. The HHS Data Integrity Board (DIB) reserves the right to monitor compliance of systems security requirements, including, if warranted, the right to make onsite inspections for purposes of auditing compliance, during the life of this agreement, or its 12-month extension period.

D. CMS and ACHA will comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. If this matching program employs systems which contain Protected Health Information (PHI) as defined by HHS regulation "Standards for Privacy of Individually Identifiable Health Information" (45 CFR Parts 160 and 164) (65 Fed. Reg. 82462 (Dec. 28, 2000)), Parts A and E. Disclosures of PHI authorized by the routine uses cited may only be made if, and as, permitted or required by the "Standard for Privacy of Individually Identifiable Health Information" (See 45 CFR 164.512(a)(1)).

IX. RECORDS USAGE, DUPLICATION, AND REDISCLOSURE RESTRICTIONS

A. Both CMS and AHCA agree to the following limitations on the access to and disclosure and use of, the tapes and information provided under this agreement.

1. That the data files provided for the data-matching program remain the property of the agency providing it and will be handled as indicated in Section VII of this agreement once processing is complete.

2. That the data supplied and the records created by the match will be used and accessed only for the purposes of, and to the extent necessary in, the matching program created by this agreement.

3. That the data provided will not be duplicated in a separate file or disseminated within or outside the agency to which it was provided for purposes other than those intended by this agreement without the written authority of the agency providing it. (See 5 U.S.C. § 552a(o)(1)(H)).

4. Other than for purposes of a particular match under this program, no file will be created that consists of information concerning only match individuals.

X. ACCURACY ASSESSMENTS

CMS estimates that at least 99% of the name, date of birth and SSNs provided to the Custodian are accurate based on their operational experience. AHCA estimates that at least

99% of the information on their matching files accurately reflects the source data based on their operational experience.

XI. COMPTROLLER GENERAL ACCESS

The General Accounting Office (Comptroller General) may have access to any records necessary to monitor and verify compliance with this agreement. The Auditor designated by Florida Medicaid program officials may have access to all CMS and AHCA data maintained by the Custodian as necessary to monitor compliance with this agreement.

XII. REIMBURSEMENT FUNDING

All work to be performed by the Custodian to carry out the match in accordance with this agreement will be performed on a contractual basis by the Custodian as prescribed in the contract between the Custodian and CMS. All work to be performed by AHCA to carry out the requirements of this matching program in accordance with this agreement will be performed on a non-reimbursable basis, except to the extent that those requirements may include administrative or other activities eligible for Federal financial participation.

XIII. APPROVAL AND DURATION OF AGREEMENT

A. This matching agreement, as signed by representatives of both agencies and approved by the recipient agency's DIB and the AHCA' approval authority will be valid for a period of 18 months from the effective date of the agreement.

B. When this agreement is approved and signed by the Chairperson of the HHS DIB, CMS, as the Federal agency, will submit the agreement and the proposed public notice of the match as attachments in duplicate via a transmittal letter to OMB and Congress for review. The time period for review begins as of the date of the transmittal letter. (A copy of the proposed *Federal Register* notice is at Attachment 11).

C. CMS will forward the public notice of the proposed matching program for publication in the *Federal Register*, as required by subsection (e)(12) of the Privacy Act, the same time the transmittal letter is forwarded to OMB and Congress. The matching notice will clearly identify the record systems and category of records being used and state that the program is subject to review by OMB and Congress. A copy of the published notice shall be provided to AHCA.

D. The effective date of the matching agreement and date when matching may actually begin shall be at the expiration of the 40-day review period for OMB and Congress, or 30 days after publication of the matching notice in the *Federal Register*, whichever is later. The parties to this agreement may assume OMB and Congressional concurrence if no comments are received within 40 days of the date of the transmittal letter. The 40-day

OMB and Congressional review period and mandatory 30-day public comment period for the *Federal Register* publication of the notice will run concurrently.

E. This agreement may be renewed for 12 months subject to the requirements of the Privacy Act, including certification by the participating agencies to the responsible DIB that:

    1. The matching program will be conducted without change, and

    2. The matching program has been conducted in compliance with the original agreement.

F. This agreement may be modified at any time by a written modification to this agreement that satisfies both parties and is approved by the HHS DIB and AHCA approval authority.

G. This agreement may be terminated at any time with the consent of both parties. If either party does not want to continue this program, it shall notify the other party of its intention not to continue at least 90 days before the end of the then current period of the agreement. Either party may unilaterally terminate this agreement upon written notice to the other party requesting termination, in which case the termination shall be effective 90 days after the date of the notice or at a later date specified in the notice provided the expiration date does not exceed the original or the extended completion date of the match.

XIV. COST-BENEFIT ANALYSIS

In 2000, Medicare program losses due to F&A, honest mistakes, and claims payment problems totaled approximately $13.5 billion. A recent report by the General Accounting Office (GAO) states that "Medicaid is at risk for billions of dollars in improper payments." (GAO, "Medicaid—State Efforts to Control Improper Payments Vary," July 10, 2001). The cost-benefit analysis for this activity is based on the results of California Medicare-Medicaid Data Analysis Center (CMMDAC) and similar previous Program Integrity F&A activities in which CMS realized a significant benefit from its efforts. In its first year of activity, the CMMDAC has produced an estimated savings of 36.8 million to the Medicare Trust Fund and to the Medi-Cal program through identification of vulnerabilities and the development of cases. In fiscal years 1988 through 1996, program integrity return on investment ranged from 11:1 to 16:1, averaging about 14:1. In layman's terms, every $1 spent on program integrity efforts yielded an average of $14 in savings. The cost for the Florida program is estimated to be 1.2 million dollars per year for the life of the program. CMS anticipates that this matching program will yield a return on investment similar with the CMMDAC and similar previous Program Integrity efforts.

XV. PERSONS TO CONTACT

A. The contact on behalf of CMS:

Lourdes Grindal Miller
Health Insurance Specialist
Centers for Medicare & Medicaid Services
Office of Financial Management
Program Integrity Group
Mail-stop C3-02-16
7500 Security Boulevard
Baltimore Maryland 21244-1850
1-410-786-1022
lgrindalmiller@cms.hhs.gov

B. The contact on behalf of AHCA:

Judy Hefren
Acting Inspector General
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308
(850) 921-4897
(850) 921-6009 (facsimile)
hefrenj@fdhc.state.fl.us

C. The contact on behalf of the Custodian:

Robert Garey
Program Director
TriCenturion, L.L.C.
P.O. Box 44007
Jacksonville, FL 32231-4007
Phone: (904) 791-8104
FAX: (904) 791-8788
bob.garey@tricenturion.com

XVI. APPROVALS

The authorized program officials, whose signatures appear below, accept and expressly agree to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commit their respective organizations to the terms of this agreement.

A. Centers for Medicare & Medicaid Services Program Officials

________________________________ Date: ____________________

Angela Brice-Smith, Acting Director
Program Integrity Group
Office of Financial Management
Centers for Medicare & Medicaid Services

________________________________ Date: ____________________

Timothy P. Love
Chief Information Officer & Director
Office of Information Services
Centers for Medicare & Medicaid Services

B. Florida Agency for Health Care Administration Program Official

______________________________________ Date: ________________________

Rhonda M. Medows, MD, FAAFP
Secretary
Agency for Health Care Administration

C. The program official on behalf of the Custodian:

_________________________________ Date: ______________________

Robert Garey
Program Director
TriCenturion, L.L.C.

XVII. DATA INTEGRITY BOARD

The respective Data Integrity Board having reviewed this agreement and finding that it complies with applicable statutory and regulatory guidelines signify their respective approval thereof by the signature of the officials appearing below.

Department of Health and Human Services Data Integrity Board

______________________________ Date: ____________________

Kerry Weems
Chairperson
Data Integrity Board
Department of Health and Human Services

Attachments:

1. CMS No. 09-70-0005--National Claims History File
2. CMS No. 09-70-0501--Carrier Medicare Claims Record
3. CMS No. 09-70-0502--Enrollment Database
4. CMS No. 09-70-0503--Intermediary Medicare Claims Record
5. CMS No. 09-70-0525--Unique Physician Provider Identification Number
6. CMS No. 09-70-0530--Medicare Supplier Identification File
7. CMS No. 09-70-0536--Medicare Beneficiary Database
8. AHCA Records File
9. Sample Data Elements for Finder File and Reply File
10. Examples of Enrollment Forms and Provider/Supplier Manuals
11. Proposed *Federal Register* Notice

Attachment 1

Centers for Medicare & Medicaid Services System of Records No. 09-70-0005

"National Claims History File"

Attachment 2

Centers for Medicare & Medicaid Services System of Records No. 09-70-0501

“Carrier Medicare Claims Record”

Attachment 3

Centers for Medicare & Medicaid Services
System of Records No. 09-70-0502

“Enrollment Database” (formerly the Health Insurance Master Record)

Attachment 4

Centers for Medicare & Medicaid Services System of Records No. 09-70-0503

“Intermediary Medicare Claims Record”

Attachment 5

Centers for Medicare & Medicaid Services
System of Records No. 09-70-0525

"Unique Physician/Provider Identification Number"(formerly known as the Medicare Physician Identification and Eligibility Record)

Attachment 6

Centers for Medicare & Medicaid Services System of Records No. 09-70-0530

"Medicare Supplier Identification File"

Attachment 7

Centers for Medicare & Medicaid Services System of Records No. 09-70-0536

"Medicare Beneficiary Database"

Attachment 8

Florida Agency for Health Care Administration Files

Claims File Layouts HIPAA Version

Download File Record File-Claims

Recipient File Layout

Provider File Layout

Attachment 9

Sample Data Elements for Finder File and Reply File

Because of the impossibility of precisely identifying beforehand all possible matching combinations, this agreement instead sets forth the following sampling of data elements contained in the Medicare and Medicaid records subject to matching.

Attachment 9-continued

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EDBW - CMS RECORD SPECIFICATION FOR EXTRACT VIEW EYMHAAB -- Row 1 to
18 of 62
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Field Name                                  Loc  Size Type Occ Req Format/Values
---------------------------------------------------------------------------
*** FINDER RECORD ***                        1   14  CHAR
        FINDER KEY                           1   11  CHAR
        FILLER                              12    3  CHAR

*** FINDER STATUS ***                       15    1  CHAR
FINDER STATUS CODE:                         15    1  NUM        012345678
 0 = NOT ON FILE
 1 = BENE_CLM_NUM MATCH
 2 = XREF_BENE_CLM_NUM MATCH
 3 = BENE_CLM_NUM EQUATE
 4 = XREF_BENE_CLM_NUM EQUATE
 5 = BENE_SSN_NUM EQUATE
 6 = UNIQUE ID MATCH
 7 = UNIQUE ID DUPLICATES
 8 = 9-CHAR MATCH (NO I/P BIC)

*** BENEFICIARY IDENTIFICATION              16   51  CHAR
BENE_IDENT_REL                              16   51  CHAR
BENE_CLM_NUM                                16   11  CHAR
   BENE_CLM_ACNT_NUM                        16    9  CHAR        Y
   BENE_IDENT_CD                            25    2  CHAR        Y
  BENE_GVN_NAME                             27   15  CHAR        Y
  BENE_MDL_NAME                             42    1  CHAR
  BENE_SRNM_NAME                            43   24  CHAR        Y
BENE_BIRTH_DT                               67    8  DATE      Y YYYYMMDD


*** SOCIAL SECURITY NUMBERS ***             75    9  CHAR
BENE_SSN_NUM_REL                            75    9  CHAR
  BENE_SSN_NUM                              75    9  NUM         Y
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Attachment 9-continued

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Record Format: FB   Record Length: 126    Block Size: 27846    Unit: CMS80
Field Name                                   Loc   Size Type Occ Req Format/Values

*** PART A ENTITLEMENT ***                   84    17  CHAR
BENE_PTA_ENTLMT_REL                          84    17  CHAR
  BENE_PTA_ENTLMT_STRT_DT                    84    8   DATE         Y   YYYYMMDD
  BENE_PTA_ENTLMT_TRMNTN_DT                  92    8   DATE             YYYYMMDD
  BENE_PTA_ENTLMT_STUS_CD                    100   1   CHAR         Y   CEGSTWXY

 *** PART B ENTITLEMENT ***                  101   17  CHAR
BENE_PTB_ENTLMT_REL                          101   17  CHAR
 BENE_PTB_ENTLMT_STRT_DT                     101   8   DATE         Y   YYYYMMDD
 BENE_PTB_ENTLMT_TRMNTN_DT                   109   8   DATE             YYYYMMDD
 BENE_PTB_ENTLMT_STUS_CD                     117   1   CHAR         Y   CFGSTWY

*** ENTITLEMENT REASON ***                   118   9   CHAR
BENE_ENTLMT_RSN_CD_REL                       118   9   CHAR
 BENE_ENTLMT_RSN_CD_CHG_DT                   118   8   DATE         Y   YYYYMMDD
 BENE_ENTLMT_RSN_CD                          126   1   NUM          Y   0123
******************************** Bottom of data ********************************
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*** Address Fields will be added to the layout by CMS**

Attachment 10

Examples of Enrollment/Application Forms and Handbooks

State of Florida Request For Assistance

Florida Medicaid Provider General Handbook

Centers for Medicare & Medicaid Services Provider/Supplier Enrollment Application (Cover Pages) CMS Form 855A, B, R, S, and I.

CMS Form 1500 Health Insurance Claim Form

CMS Form 250 Medicare Questionnaire (Series Sample)

Attachment 11

Proposed *Federal Register* Notice

Billing Code: 4120-03

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

Privacy Act of 1974

Computer Matching Program (Match No. 2003-03)

AGENCY: Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS).

ACTION: Notice of Computer Matching Program (CMP)

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, as amended, this notice announces the establishment of a CMP that CMS plans to conduct with the Florida Health and Human Services Commission (AHCA). We have provided background information about the proposed matching program in the "Supplementary Information" section below. Although the Privacy Act requires only that CMS provide an opportunity for interested persons to comment on the proposed matching program, CMS invites comments on all portions of this notice. See "Effective Dates" section below for comment period.

EFFECTIVE DATES: CMS filed a report of the CMP with the Chair of the House Committee on Government Reform and Oversight, the Chair of the Senate Committee on Governmental Affairs, and the Administrator, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB) on < DATE   >. We will not disclose any information under a matching agreement until 40 days after filing a report to OMB and Congress or 30 days after publication. We may defer implementation of this matching program if we receive comments that persuade us to defer implementation.

ADDRESS: The public should address comments to: Director, Division of Privacy Compliance Data Development (DPCDD), Enterprise Databases Group, Office of Information Services, CMS, Mailstop N2-04-27, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Comments received will be available for review at this location, by appointment, during regular business hours, Monday through Friday from 9 a.m.- 3 p.m., eastern daylight time.

FOR FURTHER INFORMATION CONTACT: Lourdes Grindal Miller, Health Insurance Specialist, Centers for Medicare & Medicaid Services, Office of Financial Management, Program Integrity Group, Mail-stop C3-02-16, 7500 Security Boulevard, Baltimore Maryland 21244-1850. The telephone number is 410-786-1022 and e-mail is lgrindalmiller@cms.hhs.gov.

SUPPLEMENTARY INFORMATION:

I. DESCRIPTION OF THE MATCHING PROGRAM

A. General

The Computer Matching and Privacy Protection Act of 1988 (Public Law (Pub. L.) 100-503), amended the Privacy Act (5 U.S.C. § 552a) by describing the manner in which computer matching involving Federal agencies could be performed and adding certain protections for individuals applying for and receiving Federal benefits. Section 7201 of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 100-508) further amended the Privacy Act regarding protections for such individuals. The Privacy

Act, as amended, regulates the use of computer matching by Federal agencies when records in a system of records are matched with other Federal, state, or local government records. It requires Federal agencies involved in computer matching programs to:

1. Negotiate written agreements with the other agencies participating in the matching programs;
2. Obtain the Data Integrity Board approval of the match agreements;
3. Furnish detailed reports about matching programs to Congress and OMB;
4. Notify applicants and beneficiaries that the records are subject to matching; and,
5. Verify match findings before reducing, suspending, terminating, or denying an individual's benefits or payments.

B. CMS Computer Matches Subject to the Privacy Act

CMS has taken action to ensure that all CMPs that this Agency participates in comply with the requirements of the Privacy Act of 1974, as amended.

Date:____________

____
Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

COMPUTER MATCH No. 2003-03

NAME:

"Computer Matching Agreement (CMA) Between the Centers for Medicare & Medicaid Services (CMS) and the State of Florida Agency for Health Care Administration (AHCA) titled "Disclosure of Medicare and Medicaid Information."

SECURITY CLASSIFICATION:

Level Three Privacy Act Sensitive

PARTICIPATING AGENCIES:

The Centers for Medicare & Medicaid Services, and
State of Florida Agency for Health Care Administration

AUTHORITY FOR CONDUCTING MATCHING PROGRAM:

This CMA is executed to comply with the Privacy Act of 1974 (Title 5 United States Code (U.S.C.) § 552a), (as amended by Public Law (Pub. L.) 100-503, the Computer Matching and Privacy Protection Act of 1988), the Office of Management and Budget (OMB) Circular A-130, titled "Management of Federal Information Resources" at 65 *Federal Register* (Fed. Reg.) 77677 (December 12, 2000), and OMB guidelines pertaining to computer matching at 54 Fed. Reg. 25818 (June 19, 1989).

This Agreement provides for information matching fully consistent with the authority of the Secretary of the Department of Health and Human Services (Secretary). Section 1816 of the social Security Act (the Act) permits the Secretary to contract with fiscal intermediaries to "make such audits of the records of providers as may be necessary to insure that proper payments are made under this part," and to "perform such other functions as are necessary to carry out this subsection" (42 U.S.C. § 1395h (a)).

Section 1842 of the Act provides that the Secretary may contract with entities known as carriers to "make such audits of the records of providers of services as may be necessary to assure that proper payments are made" (42 U.S.C. § 1395u(a)(1)(C)); "assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits" (42 U.S.C. § 1395u(a)(2)(B)); and "to otherwise assist . . . in discharging administrative duties necessary to carry out the purposes of this part" (42 U.S.C. § 1395u(a)(4)).

Furthermore, §1874(b) of the Act authorizes the Secretary to contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this title (42 U.S.C. § 1395kk(b)).

Section 1893 of the Act establishes the Medicare Integrity Program, under which the Secretary may contract with eligible entities to conduct a variety of program safeguard activities, including fraud review employing equipment and software technologies that surpass the existing capabilities of Fiscal Intermediaries and carriers (42 U.S.C. § 1395ddd)). The contracting entities are called Program Safeguards Contractors.

Pursuant to § 409.902, Florida Statutes (F.S.), AHCA is charged with the administration of the Medicaid program in Florida, and is the single state agency for such purpose. AHCA is required to operate a program to oversee the activities of Florida Medicaid recipients and providers to ensure that fraudulent and abusive behavior occurs to the minimum extent possible (§ 409.913, F.S.).

AHCA's disclosure of the Medicaid data pursuant to this agreement is for purposes directly connected with the administration of the Medicaid program, in compliance with 42 CFR 431.300 through 431.307. Those purposes are the detection, prosecution and deterrence of F&A in the Medicaid program.

PURPOSE (S) OF THE MATCHING PROGRAM:

The purpose of this agreement is to establish the conditions, safeguards, and procedures under which CMS will conduct a computer matching program with AHCA to study claims, billing, and eligibility information to detect suspected instances of Medicare and Medicaid fraud and abuse (F&A) in the State of Florida. CMS and AHCA will provide TriCenturion, a CMS contractor (hereinafter referred to as the "Custodian") with Medicare and Medicaid records pertaining to eligibility, claims, and billing which the Custodian will match in order to merge the information into a single database. Utilizing fraud detection software, the information will then be used to identify patterns of aberrant practices requiring further investigation. The following are examples of the type of aberrant practices that may constitute F&A by practitioners, providers, and suppliers in the State of Florida expected to be identified in this matching program: (1) billing for provisions of more than 24 hours of services in one day, (2) providing treatment and services in ways more statistically significant than similar practitioner groups, and (3) up-coding and billing for services more expensive than those actually performed.

CATEGORIES OF RECORDS AND INDIVIDUALS COVERED BY THE MATCH:

This Computer Matching Program will enhance the ability of CMS and AHCA to detect F&A by matching claims data, eligibility, and practitioner, provider, and supplier enrollment records of Medicare beneficiaries, practitioners, providers, and suppliers in the State of Florida against records of Florida Medicaid beneficiaries, practitioners, providers, and suppliers in the State of Florida.

DESCRIPTION OF RECORDS TO BE USED IN THE MATCHING PROGRAM

The data for CMS are maintained in the following Systems of Records:
National Claims History (NCH), System No. 09-70-0005 was most recently published in the *Federal Register*, at 67 Fed. Reg. 57015 (September 6, 2002.) NCH contains records needed to facilitate obtaining Medicare utilization review data that can be used to study the operation and effectiveness of the Medicare program. Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice.

Carrier Medicare Claims Record, System No. 09-70-0501 published in the *Federal Register* at 67 Fed. Reg. 54428 (August 22, 2002). Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice.

Enrollment Database, System No. 09-70-0502 (formerly known as the Health Insurance Master Record) published at 67 Fed. Reg. 3203 (January 23, 2002). Matched data will be released to AHCA pursuant to the routine use set forth in the system notice.

Intermediary Medicare Claims Record, System No. 09-70-0503 published in the *Federal Register* at 67 Fed. Reg. 65982 (October 29, 2002). Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice.

Unique Physician/Provider Identification Number (formerly known as the Medicare Physician Identification and Eligibility System), System No. 09-70-0525, was most recently published in the *Federal Register* at 53 Fed. Reg. 50584 (December 16, 1988). Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice.

Medicare Supplier Identification File, System No. 09-70-0530 was most recently published in the *Federal Register*, at 67 Fed. Reg. 48184 (July 23, 2002). Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice.

Medicare Beneficiary Database, System No. 09-70-0536 published in the *Federal Register* at 67 Fed. Reg. 63392 (December 6, 2001). Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice.

The data for AHCA are maintained in the following data files:

Claims File Layouts HIPAA Version
Download File Record File-Claims

Recipient File Layout

Provider File Layout

INCLUSIVE DATES OF THE MATCH:

The CMP shall become effective no sooner than 40 days after the report of the Matching Program is sent to OMB and Congress, or 30 days after publication in the Federal Register, which ever is later. The matching program will continue for 18 months from the effective date and may be extended for an additional 12 months thereafter, if certain conditions are met.

Attachment B

Procurement Sensitive

Exhibit – I: Florida Medicare/Medicaid Data Analysis Center SOW

I. SCOPE

The Florida Medicare / Medicaid Data Analysis Center (herein after referred to as Medi-Medi) shall support the Center for Medicare & Medicaid Services' (CMS) efforts to combat fraud and abuse in the Medicare and Medicaid programs by performing computerized matching and analysis of Medicare and Medicaid data. Support shall also include fraud investigation services, to identify, develop, and refer to law enforcement aberrant activities in the Medicare and Medicaid programs in the State of Florida. The results of Medi-Medi analyses shall be shared with the Medicare program Affiliated Contractors (AC) (Fiscal Intermediaries, Carriers, RHHIs, etc.), and the Florida Health and Human Services Commission (HHSC).

A. Background

CMS has increased its efforts to use advanced technology to detect and prevent fraud and abuse and to ensure that CMS pays the right provider the right amount, for the right service, on behalf of the right beneficiary. Combining claims data from two major payers for health care services, Medicare and Medicaid, to search for aberrancies indicative of fraud or abuse, should increase the likelihood of detecting activity that may fall below the detection threshold in either program individually. Reasons for this include the fact that many providers serve both the Medicare and Medicaid-eligible populations, and that there are a large number of beneficiaries eligible for both Medicare and Medicaid benefits. Substantial administrative hurdles, however, have generally prevented the combining of data, and the benefits that would flow there from.

The following provides background information on the Florida Medicaid program:

Number of Florida Medicaid beneficiaries: 2,100,000

Number of Florida Medicaid providers: over 90,000 active provider numbers as part of over 75,000 provider entities. (Note: Some entities have multiple provider numbers.)

Number of claims processed per-year by the Florida Medicaid Agency: over 120,000,000

Florida data is refreshed monthly, and the State will provide its data via NDM. Florida's data format follows VSAM, but it is also capable of providing the data in the form of a relational database via its Data Warehouse. The exact data to be included in the extract shall be identified during future meetings with HHSC and the PSC, but the State Agency will make data dictionaries available for the PSC to use for the Medicaid files.

For more information concerning Florida's information technology capabilities, the PSC should contact David Powers (powersd@fdhc.state.fl.us)

B. Purpose

The purpose of the Medi-Medi is to pursue the hypothesis that examining health care claims data from multiple health care programs that share a number of common beneficiaries and providers for aberrancies indicative of fraud or abuse will increase the likelihood of detecting aberrant activity falling below the detection threshold of any single program.

The expected outcomes for this Statement of Work are:

- Maintenance of a conveniently located, appropriately secured data center and work facility;
- Combining the most recent three years worth of health care claims data from the Medicare and Medicaid programs;
- Identification and use of data matching and analysis methods and techniques to detect and develop potential fraud cases;
- Statistical analysis and trending activities;
- Proper support in the development of appropriate and quality potential fraud cases for referral to appropriate health care oversight or law enforcement agencies; and
- Establishment and maintenance of good working relationships and extensive networking with both internal components and external partners.

II. REQUIREMENTS

General

The PSC shall provide a variety of data analysis, statistical analysis, and trending activities to enhance the detection and prevention of Medicare and Medicaid fraud and abuse in the State of Florida. The PSC shall use appropriate CMS Medicare data, as well as data from other sources such as Medicaid data, to reach this end.

The activities outlined in this Statement of Work are intended to enhance the current benefit integrity worked performed by TriCenturion under contract # 500-99-0011/0007 and integrated into its work to prevent, identify, and address potential fraud in the Florida region. Successful accomplishment of this Statement of Work shall require a significant amount of cooperation with HHSC and law enforcement.

The required services are delineated in this SOW and include activities such as:

- Employing qualified professionals for performing proactive data analysis;
- Exploring potential Medicare fraud leads in Florida;
- Creating and maintaining a Medicare/Medicaid claims database containing the most recent 36 months worth of data;
- Developing appropriate, well developed and well documented cases for referral to civil and criminal law enforcement authorities;
- Identifying payments made as a result of potential fraud;
- Identifying program vulnerabilities; and

- Completing all reporting requirements.

In general, the PSC shall combine Medicare and Medicaid data, pursue potential fraud leads through proactive data matching and analysis, perform analyses requested by law enforcement entities, develop potential fraud cases, and produce reports that will serve as case referrals. Additional tasks not currently identified may be associated with this SOW. CMS reserves the right to expand upon this current workload for similar activities as required.

Systems

The Medi-Medi shall possess hardware, software and telecommunications equipment sufficient to effectively perform the tasks required by this Statement of Work. The PSC shall maintain back-up copies of all critical software and data.
The PSC shall have the capability to:

- Receive and transmit data to the CMS Data Center;
- Read and write 3490 tape cartridges;
- Read and write to compact disks (CDs);
- Back up all changing data on, at minimum, a weekly basis; and
- Receive and produce files in the following formats or current version that CMS is using: Microsoft Office 97, Bitmap (BMP), Joint Photographic Experts Group (JPEG), Graphics Interchange Format (GIF), Hyper Text Markup Languages (HTML) or other industry standard formats as specified by the Government Task Leader (GTL) or Co-GTL (GTLs).

The PSC shall evaluate its information technology systems on an annual basis, and, if applicable, make recommendations for changes.

This task order will be implemented in two (2) phases.

1. Preparation for Full Implementation of Medi-Medi
2. Option 1: Full Implementation of Medi-Medi

Progression to Option 1 is contingent upon ratification and approval of the Computer Matching Agreement and contract modification to exercise the option.

A. Specific Tasks to Be Performed

Preparation for Full Implementation of Medi-Medi

Task 1: Kickoff Meeting

The PSC shall plan and participate in an initial meeting/kickoff conference between the Government Task Leaders (GTLs), and the HHSC within 30 days of award of this TO in order to plan for the development of the Medicare/Medicaid database. The PSC and the GTL will mutually determine the time, date, agenda and location of the initial kickoff conference after consultation with the state.

During the kickoff conference, the PSC shall distribute its draft Project Plan (See Task 2) and establish implementation teams to ensure that communication, coordination, and consultation between the PSC and state is developed and maintained during the course of the project. The PSC shall take minutes of this meeting and any subsequent meetings in order to document the discussion and actions items for distribution to all participants no later than 7 days following each meeting.

Task 2: Project Plan

The PSC shall develop a project plan detailing the steps and timeframes for accomplishing all the work defined in this task order. The project plan shall be modified and updated continuously after these initial submissions to reflect any major changes in the project. The draft project plan shall be submitted within 30 calendar days of contract award. The final project plan shall be submitted within 60 calendar days of contract award.

Task 3: Information Technology (IT) Systems Plan

IAW SOW Section II.B.4, the PSC shall incorporate the Medi-Medi Data/Systems Plan into the overall TRICENTURION IT Systems Plan and make any updates as needed on an ongoing basis. In addition, for the purposes of the Medi-Medi, the PSC shall prepare a detailed plan that outlines how it shall receive, store, safeguard, manipulate, and analyze data necessary to perform these tasks. This data/systems plan shall, at a minimum, include the following:

- A list and description of Medicare data the PSC would want to access that is not stored at CMS,
- A list and description of State of Florida-owned Medicaid data the PSC would want to access,
- A list and description of other data files necessary to conduct the data analysis, given the constraints that only data stored at CMS would be provided by the PO,
- A schedule of how often new or updated data would be needed (e.g., daily, weekly, monthly),
- A description of the software systems, products, and tools that are being proposed for use under this Statement of Work, including any licensing restrictions,
- A certification that the hardware and software being proposed have the capacity to manipulate the anticipated volume of data,
- A description of how the PSC plans to use the hardware and software products,
- A description of how the PSC will ensure compliance with The Privacy Act of 1974, CMS Security Requirements, and applicable Florida law,
- A discussion of how the proposed PSC data systems environment is appropriate, given CMS' system architecture, and
- Other items as identified by the PSC.

Task 4: Monthly Progress Report

The PSC shall submit to CMS and HHSC a monthly progress report, by the 15th of the month, that reflects the previous month's effort. This report is separate from the base work in the contract. See reporting requirements for specifics to be reported. In addition, the PSC shall conduct at a minimum monthly meetings with the GTL's to resolve open issues, discuss the status of activities, and identify other reporting requirements or performance indicators as appropriate.

Task 5: Joint Operating Agreement

The PSC shall develop a Joint Operating Agreement (JOA) that shall specify the routine operations level interactions between the PSC and HHSC, and any other parties as may be necessary. The JOA shall be modified and updated to reflect any changes in the project. The PSC shall submit to CMS the draft JOA 45 calendar days after contract award. The PSC shall submit to CMS the final JOA 90 calendar days after contract award.

Task 6: Remote User Support and Access

The PSC shall provide a minimum of three Florida Medicaid staff with access to the joint Medicare/Medicaid database within four (4) months of exercising Option 1 for use in the research and development of their own fraud cases. This access should include initial training on the database and ad hoc support as needed.

Option 1: Full Implementation of Medi-Medi

This option period is for 12 months from the date the option is exercised. Subsequent years may be renewed IAW contract section H.1 Contract Renewal.

Option 1, Task 7: Data Analysis

The Medi-Medi shall use Medicare Part A, B, DMERC and Medicaid data for the entire State of Florida to provide comprehensive problem identification and research, data analysis and trending to CMS in a coordinated, efficient, and effective manner. As part of this task, the PSC shall match the most recent 36 months worth of Medicare and Medicaid claims data for the creation of a database that can be used for data analysis purposes.

The PSC shall use such means necessary to research and analyze data, and in such a format, as to permit the PSC, the ACs and HHSC to be able to utilize the data for purposes of fraud and abuse analysis and detection. To ensure HHSC' ability to utilize the data for such purposes, the PSC shall work closely with HHSC to assure or the appropriate state agencies (including state IT entities) direct, secure, on-line access during normal business hours to receive matched data and applications used to assess matched data. Key to this is consideration of competing agencies/interests and prevailing operational requirements. Details of these arrangements shall be addressed in a joint operating agreement to be agreed upon by the PSC and HHSC. Data will be updated by the PSC on a monthly basis.

The PSC shall identify potential Medicare and/or Medicaid program vulnerabilities that may result or have resulted in inappropriate Medicare and/or Medicaid payment due to abuse or potential fraud. Armed with this knowledge, the PSC shall perform a wide variety of data matching, analysis, trending, and statistical activities to enhance the detection and prevention of Medicare and Medicaid fraud and abuse in the State of Florida. Data analysis activities should enable the PSC to quickly identify the scope and potential impact of emerging program integrity issues, and may require quick turnaround data runs. The PSC shall provide a summary of data analysis efforts and findings in the Monthly Progress Report (See Reporting Requirements for the details to be submitted in this report).

Types of data analysis performed may include:
- Analyzing data for a particular service or group of services that appear to be experiencing unusual growth in utilization;
- Analyzing data for a specific time frame;
- Analyzing data for a particular provider or beneficiary demographic;
- Examining utilization patterns and trends for newly covered services;
- Determining if a particular claims system edit is having the intended effect;
- Performing and validating new types of analysis or experimental analysis; and
- Other analysis as may be identified by the PSC.

Upon approval of the GTLs, the PSC shall prepare in-depth data analysis reports focusing upon particular problems that are complex, long term, and/or that demand particular scientific methods of analysis. The PSC shall recommend topics, as necessary, for such in-depth reports. Concepts for data analysis focus areas shall be discussed with the GTLs before a more comprehensive analysis shall take place. The PSC shall provide an update of progress on any in-depth reports in the Monthly Status Report, and shall notify the GTLs of its findings upon completion of the analysis. The GTLs and PSC shall mutually agree upon the format and scope of this notification after award.

Option 1, Task 8: Development and Referral of Potential Fraud Cases

Fraud cases shall be developed IAW the Umbrella SOW and this task order. The PSC shall refer potential fraud to the appropriate State or Federal law enforcement agency.

Option 1, Task 9: Medi-Medi Steering Committee

The PSC shall provide full administrative support, including provision of meeting space and preparation and distribution of meeting minutes, for the Medi-Medi Steering Committee, which should meet not less frequently than quarterly. The actual schedule will be determined jointly by CMS, the PSC, and participating state agencies. The Medi-Medi Steering Committee shall consist of agencies including, but not limited to, CMS, FBI, DHHS, OIG, HHSC, and the Office of Investigations and Enforcement Health and Human Services Commission in Florida. The PSC shall prepare minutes as a result of this meeting, which shall be furnished to all attendees within 10 days after the meeting was held.

Option 1, Task -10: Lessons Learned Report

The PSC shall submit a report discussing the lessons learned by the Medi-Medi team during the process of matching and combining the Medicare Part A, B, DMERC, and Medicaid data. This report should be submitted to the GTLs no later than 30 days prior to the end of the first contract year.

B. Report Requirements

All written documents for this project shall be delivered to the GTLs via a single hard copy plus an electronic version via email. The GTLs or HHSC may request additional hard copies as necessary. All electronic files shall be submitted in a format that is compatible with Microsoft Office 97. This is subject to change, and the PSC shall be prepared to submit deliverables in any new CMS standard.

The GTLs shall provide the PSC with comments on draft reports within two (2) weeks of receipt. HHSC shall coordinate with the GTLs to provide its comments on draft reports within two (2) weeks of receipt. If no response is received within two (2) weeks, the PSC shall assume that the draft report is approved for development of final reporting.

1. **Project Plan:** The project plan shall include, at a minimum, the following information (not necessarily in the order presented here):

   - Work Breakdown Structure;
   - Key staff types devoted to each task or activity, if appropriate, and time allocation for each;
   - Key milestones signifying successful completion of each task and periodic internal assessment/progress reports planned; and
   - Activity interdependency and critical path for completion of all tasks.

2. **Monthly Status Report:** The Monthly Status Report shall include at a minimum:

   - A Summary of Current Investigations including:
     - The source of the investigation (self-initiated, proactive data analysis, contractor referral, law enforcement referral, etc.);
     - The nature of the investigation, including the potential violations;
     - The name(s) of the provider(s) under investigation shall not be included by name in the report, but shall be available to CMS & HHSC if needed; and
     - Potential Medicare and/or Medicaid dollars at risk.
   - A full report of its efforts and findings for any in-depth data analysis reports completed during the month, as well as a summary of activities and preliminary findings for any ongoing in-depth data analysis reports;
   - Data and statistical assistance initiated and/or completed;
   - The cost management report, which shall delineate the hours and costs incurred by labor category by specific activity in each task for the previous month's efforts;
   - Report of any continuous quality improvement activities and findings.
   - A cumulative status on all cases referred to law enforcement by the PSC, or by ACs or HHSC pursuant to information provided by the PSC, and including the following information:

     - The provider(s) being referred and date of referral;
     - The nature of the case, including potential Medicare and/or Medicaid violations

- The date of law enforcement acceptance or declination;
- Final disposition, such as civil or criminal prosecution or administrative action; and
- Overpayments collected by the Medicare carrier or FI, the Medicaid Fiscal Agent, HHSC and/or the Office of Investigations and Enforcement Health and Human Services Commission in Florida .

3. **Meeting Minutes from the Medi-Medi Steering Committee**: Minutes for the Medi-Medi Steering Committee shall include at a minimum:

    - List of Attendees
    - Subjects Discussed
    - Action Items

4. **Lessons Learned Report:**

    The Lessons Learned Report should include challenges the team encountered during the process and knowledge gained about the differences between the Medicare and Medicaid programs. The specific content of this report should be agreed upon by the PSC and the GTLs no later than 60 days prior to the end of the first contract year.

5. **JOA:**

    The JOA shall include at a minimum information on:
    - Communication between Medi-Medi and HHSC
    - Systems
    - Processes for coordination between Medi-Medi and HHSC

    The JOA should include signed approval from contributing state agencies such as IT and other affected operational units reflecting the impact of the operation. Specific limitations on access to the matched data as determined by the state should also be included. The specific content of this report shall be agreed upon by the PSC and HHSC.

6. **Cost Report**

    The PSC shall report all costs associated with the Medi/Medi project in Task 24 of the PSC cost report. In addition, the PSC shall break out all travel and other direct costs associated with the Medi/Medi workload as part of their monthly cost report.

C. Personnel Requirements

All PSC and subcontractor personnel working on this Statement of Work must obtain a signed Non-Disclosure Statement prior to the start of the project. The PSC shall retain the Non-Disclosure Statements on file at the place of performance.

The personnel requirements will conform with the TRICENTURION SOW section II.C titled Personnel Requirements.

III. QUALITY ASSURANCE

The Quality Assurance requirements will conform with the TRICENTURION SOW section III.B titled Quality Assurance.

APPENDIX A

ITEMS TO BE FURNISHED AND DELIVERABLE SCHEDULE

The PSC shall submit all required reports and deliverables in accordance with the following schedule. Reports and/or deliverables submitted under this contract shall be in accordance with this Statement of Work.

TBD = To Be Determined
IAW = In Accordance With
PO = Project Officer
CO = CO & CS
DOA = Date of Award
GTL = Government Task Leader
SP = Special Project
SP SOW = Special Project Statement of Work (Medi-Medi Statement of Work)

Deliverable	Description	Quantity	Recipient	Delivery Date
1	Project Plan IAW SP SOW Section II.A.2	1 hard copy and electronic copy	GTL Co-GTL	Draft: 30 calendar days after contract award Final: 60 calendar days after contract award
2	IT Data Systems Plan IAW SP SOW Section II.A.3	1 hard copy and electronic copy	GTL Co-GTL	In accordance with TRICENTURION SOW
3	Draft Security Plan See Task Order SOW	See Task Order SOW	See Task Order SOW	See Task Order SOW
4	Final Security Plan See Task Order SOW	See Task Order SOW	See Task Order SOW	See Task Order SOW
5	Medi-Medi Steering Committee Meeting Minutes IAW SP SOW Section II.A.9	1 hard copy and electronic copy	All Medi-Medi Steering Committee Attendees	Within 10 days after Medi-Medi Steering Committee Meeting
6	Monthly Progress Report IAW SP SOW Section II.A.4	1 hard copy and electronic copy	GTL Co-GTL CO	15th of every month
7	Lessons Learned Report IAW SP SOW Section II.A.10	1 hard copy and electronic copy	GTL Co-GTL	30 days prior to the end of the 1st contract year
8	Joint Operating Agreement (JOA) IAW SP SOW Section II.A.5	1 hard copy and electronic copy	GTL Co-GTL	Draft – 45 calendar days after contract award Final – 90 calendar days after contract award Quarterly thereafter

Recipient(s) Addresses:

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Attachment C

FY 2005 1st Quarter Report on Medicare / Medicaid Data-Match (Medi-Medi) Projects

The first quarter of FY 2005 has seen burgeoning progress in our efforts to reduce health care fraud, waste, and abuse in the Medicare and Medicaid programs. This is the first full quarter in which seven of the Medi-Medi projects have produced compelling data leads, promising investigations, and high quality case referrals to law enforcement. The preceding months were spent developing and finalizing a number of Computer Matching Agreements; acquiring and matching claims and enrollment data from the state Medicaid agencies; developing and prioritizing data analysis algorithms; and meeting with law enforcement and the respective states to establish case referral processes.

The table below summarizes the amount of program dollars at risk from potential fraud and abuse schemes. It also highlights the number of investigations and cases that the states and Program Safeguard Contractors (PSCs) have developed. Because some work in the six expansion states was performed before the first quarter of FY 2005, the figures below are cumulative and thus represent progress made from the inception of each Medi-Medi project through December 31, 2004.

CMS HCFAC Report on
Medicare / Medicaid Data-Match Project (from Inception to December 31, 2004)

State	No. of Investigations Initiated: Medicare and/or Medicaid	No. of Case Referrals To Law Enforcement	*Potential Dollars at Risk: Medicare and Medicaid Investigations	*Estimated Impact: Medicaid Vulnerabilities Identified	*Estimated Impact: Medicare Vulnerabilities Identified	Combined: *Potential Dollars at Risk for Investigations and *Estimated Impact for Vulnerabilities	*Overpayment Amounts Identified
California	117	13	$70.5 Million	$5.9 Million	$16.9 Million	$93.3 Million	$1,972,312[1]
Florida	5	0	$7.2 Million	$14.3 Million	$0	$21.5 Million	$0
Illinois	54	9	$26.9 Million	$6.7 Million	$6.7 Million	$40.3 Million	$0
New Jersey	12	0	$1.7 Million	$0	$0	$1.7 Million	$0
North Carolina	11	2	$0.3 Million	$0.4 Million	$6.6 Million	$7.3 Million	$0
Pennsylvania	6	0	$3.3 Million	$2.2 Million	$0	$5.5 Million	$0
Texas	5	1	$7.4 Million	$0	$0	$7.4 Million	$0
Total	**210**	**25**	**$117.3 Million**	**$29.5 Million**	**$30.2 Million**	**$177 Million**	**$1,972,312**

* **Potential Dollars at Risk** represent the amount of dollars paid to a provider that relates to the allegation(s) under investigation.

* **Estimated Impact** represents the potential amount of dollars at risk resulting from programmatic vulnerabilities that have been identified.

* **Overpayment Amounts Identified** represent the dollar amount of overpayments referred to the Affiliated Contractor (Fiscal Intermediary or Carrier) for recovery.

The above figures—especially, the potential dollars at risk, the potential impact related to programmatic vulnerabilities, and the number of investigations that have resulted from each project—are promising. Please note, however, that the estimated savings figures are based upon each PSC's projected amount of dollars from a suspected fraud and abuse scheme or vulnerability for a particular timeframe. Given the length of time it takes to develop a case and the difficulty of identifying the type and scope of fraud schemes and vulnerabilities before concluding a full investigation, there are recognized differences among PSCs in the methods used to estimate amounts of program savings. Nonetheless, at this stage, we believe these are good indicators of each Medi-Medi project's effectiveness. Naturally, as each project matures, we anticipate that the methodology behind these program savings estimates will be refined as reporting becomes more consistent across all Medi-Medi projects.

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[1] Because California has been matching data for nearly three years, it has had an opportunity to develop cases to their final disposition and to, where appropriate, refer identified overpayments to fiscal intermediaries and/or carriers for recovery. We expect that the other Medi-Medi projects, which have recently begun to match data, will identify overpayments as they have the opportunity to further develop their cases.

Medi-Medi Investigations and Cases

The Medi-Medi program produces a variety of benefits. Among other things, it generates investigations and cases by analyzing services purportedly provided by providers who serve both Medicare and Medicaid beneficiaries. Individual Medi-Medi projects uncovered a variety of schemes and made progress on investigations initiated in previous quarters. The following examples show the value of the Medi-Medi program.

By analyzing Medicare and Medicaid data simultaneously, PSCs have been able to identify "time bandits," i.e., providers who bill more hours than are possible in a day, more days than are possible in a given month, or more days than are possible in a given year. For example, in 2003, data examined in the New Jersey Medi-Medi project showed that a provider billed more than 24 hours for 131 days. Before this billing pattern was identified, the provider had not been investigated by either Medicare or Medicaid. Without the Medi-Medi project, this billing pattern may not have been discovered.

The Medi-Medi program has also helped to undercover other types of fraud and abuse schemes, such as "beneficiary sharing rings" and "unbundling." In a beneficiary sharing ring, certain providers obtain a list of beneficiaries and bill as if they have provided services to the beneficiaries. In fall 2004, the Illinois Medi-Medi project identified more than a thousand providers who appear to be involved in this scheme. In fact, fifteen of these providers received payments in excess of $3,400,000.[2]

Likewise, the Medi-Medi program has helped to expose providers who unbundle services. "Unbundling" occurs when a provider attempts to increase reimbursement by billing multiple procedure codes for a group of procedures that are covered by a single comprehensive code. In fall 2004, the North Carolina Medi-Medi project uncovered a hospice provider that was unbundling services and inappropriately billing both Medicare and Medicaid in excess of $6,600,000.

The California Medi-Medi project presents another example of the striking results of concentrated efforts by a PSC. During the last quarter, it was able to close a long-standing investigation. In January 2003, the California Medi-Medi project initiated an investigation on a general practice physician who was potentially allowing another provider to bill under his provider number. Medi-Medi data showed that the other provider was rendering the services that the general practice physician was submitting. In fact, 114 out of 115 records reviewed showed that the other provider was rendering the services. In January 2004, the general practice physician was referred to the Carrier for pre-payment medical review. In May 2004, it was discovered that the noted physician had begun to submit claims under a new provider number with a radiology group. Subsequent records review revealed that, once again, another provider was rendering the services. As a result, a medical review was performed on this radiology group provider number. These efforts culminated in December 2004 when the California Medi-Medi project referred an overpayment of $919,000 to the Carrier for recovery.

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[2] The large volume of providers potentially involved in the beneficiary sharing ring accounts for the unusually high number of dollars at risk and investigations underway in Illinois as reported in the table above.

Finally, through the North Carolina Medi-Medi project, a nurse practitioner was identified as being the most frequent prescriber of power wheelchairs in that state. Analysis of 2003 claims data suggested that this practitioner prescribed power wheelchairs for a number of patients for whom she did not provide services. In addition, evidence obtained during the investigation suggested that the nurse practitioner had an inappropriate business relationship with the wheelchair supplier. The PSC has determined that Medicare has paid $405,000 to suppliers for power wheelchairs prescribed by this nurse practitioner. It is coordinating with the state and other contractors to determine the extent to which Medicaid payments are implicated.

Status of Expansion into Ohio and Washington

In September 2004, we expanded the Medi-Medi projects to include Washington and Ohio. The Ohio and Washington Medi-Medi projects have made progress developing the Computer Matching Agreement (CMA). Although data may not be matched and shared until the CMA process is finalized, Ohio and Washington have been busy developing Joint Operating Agreements (JOAs) and planning the receipt and matching of Medicaid data. In addition, the state of Ohio and the PSC have exchanged information on current investigations and providers on pre-payment medical review. The Washington Medi-Medi project has been mapping Washington Medicaid's data dictionaries in preparation for the data match.

Final Funding Levels

Nine Medi-Medi states were funded from the following sources for contract year 2005 (September 30, 2004 through September 29, 2005):

$6.3 Million	HCFAC apportionment
$3 Million	FBI Interagency Agreement
$1.5 Million	Medicare Integrity Program Funds
$1 Million	Unexpended end-of-year HCFAC funds

Thus far for contract year 2006 (September 30, 2005 through September 29, 2006), the only funds committed to date total $4.838 million from the HCFAC apportionment. Consideration is being given to approaches in reducing the level of effort in the Medi-Medi program if additional funding is not identified.

Attachment D

FY 2005 2nd Quarter Report on Medicare/Medicaid Data-Match (Medi-Medi) Projects

Funding Levels

A total of $4.838 million from HCFAC apportionment and an anticipated $1 million from the FBI through an Interagency Agreement account for the only funds committed to date to the Medi-Medi Projects for contract year 2006 (September 30, 2005 through September 29, 2006).

It should be noted that consideration is being given to reducing the level of effort commensurate with reduced funding levels for FY 2006. It is anticipated that these projects will have to be operated with approximately half the funding available in this current fiscal year. Eliminating certain Medi-Medi projects in their entirety and/or dramatically reducing the level of effort across all of the projects are among the approaches under consideration. Beyond FY 2006, the entire project will terminate if additional funding is not identified.

Progress Report

As with the first quarter, the second quarter of fiscal year 2005 shows that we are making steady progress in our efforts to reduce health care fraud, waste, and abuse in the Medicare and Medicaid programs. In the second quarter of this effort, seven fully operational Medi-Medi projects have produced compelling data leads, promising investigations, and high quality case referrals to law enforcement.

The tables below summarize the amount of program dollars at risk from potential fraud and abuse schemes. They also highlight the number of investigations and cases that the states and Program Safeguard Contractors (PSCs) have developed. The figures for the first table (below) represent the 2nd quarter reporting period (January - March 2005). The figures for the second table (on the next page) are cumulative and thus represent progress made from the inception of each Medi-Medi project through March 31, 2005.

FY 2005 2nd Quarter Report CMS HCFAC Report on Medicare/Medicaid Data-Match Projects (from January 2005 - March 2005)

State	No. of Investigations Initiated: Medicare and/or Medicaid	No. of Case Referrals to Law Enforcement	*Potential Dollars at Risk: New Medicare and Medicaid Investigations	*Estimated Impact: Medicaid and/or Medicare Vulnerabilities Identified	*Overpayment Amounts Identified	Denied Claims Prepayment Edits/Medical Review
California	6	1	5.7 million	0	$ 4,499	3.8 million
Florida**	4	N/A	12 million	N/A	N/A	N/A
Illinois	6	0	1.0 million	0	0	0
New Jersey	4	0	1.1 million	0	$46,059	0
North Carolina	5	3	1.4 million	0	$ 4,063	0
Pennsylvania	2	0	1.7 million	0	0	0
Texas	4	1	.5 million	0	0	0
Totals	31	5	23.4 million	0	$54,621	3.8 million

* **Potential Dollars at Risk** represent the estimated amount of dollars paid to a provider that relates to the allegation(s) under investigation.

* **Estimated Impact** represents the potential amount of dollars at risk resulting from programmatic vulnerabilities that have been identified.

* **Overpayment Amounts Identified** represents the dollar amount of overpayments referred to the Affiliated Contractor (Fiscal Intermediary or Carrier) for recovery.

** **Florida is in the process of transitioning contractors for an issue unrelated to the Medi-Medi project.**

FY 2005 2nd Quarter Report on Medicare/Medicaid Data-Match (Medi-Medi) Projects

Cumulative CMS HCFAC Report on Medicare/Medicaid Data-Match Projects (from Inception to March 31, 2005)

State	No. of Investigations Initiated: Medicare and/or Medicaid	No. of Case Referrals to Law Enforcement	*Potential Dollars at Risk: Medicare and Medicaid Investigations ALL CASES AND INVESTIGATIONS	*Estimated Impact: Medicaid and/or Medicare Vulnerabilities Identified	*Overpayment Amounts Identified	Denied Claims Prepayment Edits/Medical Review
California	123	14	76.2 million	22.8 million	$1,976,811	3.8 million
Florida **	4	N/A	12 million	14.3 million	N/A	N/A
Illinois	60	9	27.9 million	13.4 million	0	0
New Jersey	16	0	2.8 million	0	46,059	0
North Carolina	16	3	1.7 million	7 million	4,063	0
Pennsylvania	12	0	4.6 million	2.2 million	0	0
Texas	9	2	7.9 million	0	0	0
Total:	240	28	133.1 million	59.7 million	$2,026,933	3.8 million

* **Potential Dollars at Risk** represent the estimated amount of dollars paid to a provider that relates to the allegation(s) under investigation.

* **Estimated Impact** represents the potential amount of dollars at risk resulting from programmatic vulnerabilities that have been identified.

* **Overpayment Amounts Identified** represents the dollar amount of overpayments referred to the Affiliated Contractor (Fiscal Intermediary or Carrier) for recovery.

** **Florida is in the process of transitioning contractors for an issue unrelated to the Medi-Medi project.**

The benefits of the Medi-Medi projects are multi-dimensional and are difficult to quantify in one "savings" number. While the figures associated with the above noted categories (e.g., potential dollars at risk, estimated impact of vulnerabilities, overpayments, and denied claims) are good indicators of success and effectiveness, they are too dissimilar to aggregate. Furthermore, given the length of time it takes to develop a case and the complexity of identifying the scope of fraud schemes and vulnerabilities, PSCs vary in the methods they use to estimate dollars at risk and the impact of identified program vulnerabilities. As each project matures, we anticipate that the methodology behind these program savings estimates will be refined.

Medi-Medi Fraud Schemes

Individual Medi-Medi projects continue to uncover a variety of health care fraud schemes and make progress on investigations that were initiated in previous quarters. We have compiled a catalog of the various data-analysis hypotheses designed to uncover different fraud schemes across all the Medi-Medi projects through March 2005. The catalog contains analytical abstracts arranged around five areas or themes: Time Analysis Studies, Beneficiary Focused Studies, Institutional (e.g., Hospital and Hospice) Focused Studies, Prescription Drug Studies, and a section for other assorted studies. The abstracts indicate that the Time Analysis Studies have proven to be the most productive projects so far with a number of investigations and cases developed across a number of different PSC jurisdictions. The Beneficiary Focused Studies contain projects designed to identify beneficiary sharing schemes among various providers, payments for deceased beneficiaries, and drug abuse patterns. The Institutional Focused Studies contain a productive analysis on the unbundling of hospice services. One of the two Prescription Drug Studies documented has produced some investigations while the other has added value as a secondary indicator to other PSC investigations. The final section of the catalog contains noteworthy abstracts which identify several investigative leads and three program vulnerabilities involving a variety of Medicare Part B providers, including DME suppliers peddling wheelchairs (K0111), physical therapists, and the abusive billing of injection codes.

Status of Expansion into Ohio and Washington

In September 2004, we expanded the Medi-Medi projects to include Ohio and Washington. Both projects have moved closer to matching Medicare and Medicaid data through a Computer Matching Agreement (CMA).[1] In addition, both projects have conducted their first steering committee meeting with law enforcement. It is anticipated that the Medi-Medi projects in both states will be operational in the next quarter.

Status of Florida Transition

In December 2004, CMS opted not to renew its contract with TriCenturion's Florida PSC task order. The PSC work and affiliated Medi-Medi project for Florida was subsequently re-bid and awarded to EDS on January 25, 2005, with the FLA-BISC becoming operational on March 1, 2005. As a result of this transition to EDS, the Florida Medi-Medi project has been interrupted while the CMA is being updated to reflect the new contractor. We anticipate that the Florida CMA will be completed in May, thereby allowing EDS to begin reconstituting the Medi-Medi data-warehouse and resuming work on the project.

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[1] A CMA establishes the conditions, safeguards, and procedures under which CMS agrees to disclose data where there is a computerized comparison of two or more automated system of records. Under the Privacy Act of 1974, a "system of records" is defined "as a group of any records under the control of a Federal agency from which information is retrieved by [a person's name] or by some identifying number, symbol, or other identifying particular assigned to [a person, such as a social security number]." 5 U.S.C. § 552a (a) (5).

Questions for the Record From Senator Rockefeller
Senate Finance Committee Hearing on
Medicaid Fraud and Abuse
Witness: Dennis G. Smith
June 28, 2005

Mr. Smith, I have ongoing concerns about the Administration's approval of comprehensive 1115 waivers which appear to undermine the core objectives of the Medicaid and SCHIP programs. In fact, Senator Baucus and I introduced legislation on this very issue last year – the Medicaid and CHIP Safety Net Preservation Act. From California, to Florida, to Iowa and even in my home state of West Virginia, these waivers are negotiated in the dark of night and under a cloud of secrecy. Providers and beneficiaries are largely locked out of the process, even though they are the ones who ultimately bear the brunt of the changes.

Question 1:

Mr. Smith, don't you agree that the waiver process should be more transparent and should involve providers and beneficiaries in a meaningful way?

Answer:

I agree with you on the need for transparency and broad consultation on waiver proposals and the Department provides ample opportunity for public input at both the state and federal level. As you know, we strongly believe in the ability of the 1115 waivers to provide states much-needed flexibility to address the needs of individual states. When a state submits a section 1115 waiver application, it must show that it has adhered to the requirements for public input that are described in the Federal Register, Vol. 59, No. 186, dated September 1994, and, if applicable to the waiver, consulted with American Indian/Alaska Native Tribes. Moreover, we are always open to receiving public comment on the state proposals. Such comments are very helpful in fully understanding the proposals and assists us in our review process.

Question 2:

What steps has CMS undertaken to allow more opportunities for public input and involvement in the process?

Answer:

The Department provides ample opportunity for public input at both the state and federal level. As you know, we strongly believe in the ability of the 1115 waivers to provide states much-needed flexibility to address the needs of individual states. When a state submits a section 1115 waiver application, it must show that it has adhered to the requirements for public input that are described in the Federal Register, Vol. 59, No. 186, dated September 1994, and, if applicable to the waiver, consulted with American Indian/Alaska Native Tribes. A copy of the proposal is placed on our website www.cms.hhs.gov/medicaid/waivers. Significant subsequent documents are also placed on the website. CMS reviews all comments submitted regarding waiver proposals to gain a comprehensive understanding of the proposal and to inform us about perceived potential problems.

At HHS, we take our public information responsibilities very seriously. We will continue to work to improve the transparency and timeliness of information on Medicaid waivers.

Question 3:

The CMS waiver website which lists pending and approved waivers indicates that it was last updated on "Thursday, September 16, 2004" even though several Medicaid and SCHIP waiver requests have been submitted and approved since that time. How often is the CMS website updated to reflect submitted and approved waivers?

Answer:

Under Public Law 104-231, the Electronic Freedom of Information Act of 1996, I understand that, on or about September 16, 2004, CMS performed a file search of all documents and posted the pertinent documents to the CMS website on that date. As a result, many website pages reflect that date at the bottom of the page. If an approval, disapproval or some other waiver action has taken place in a state, then the update may be reflected in the link rather than on the opening page. For instance, the website for the Montana waiver program (www.cms.hhs.gov/medicaid/waivers/mtwaiver.asp) is designated as being last modified on September 16, 2004. However, following the link to Montana waivers operating under 1115 authority (www.cms.hhs.gov/medicaid/1115/mtfp.asp), then the page is designated as last modified on April 14, 2005.

Of the websites for the 50 states, 30 are listed as last modified in September 2004 and of those, 6 have links to recently updated information. The remaining 20 websites have modification dates within the last 6 months. More current information would not be available on the website if states have not submitted changes to their existing program.

CMS is currently in the process of redesigning its website in an attempt to make information more readily available to the public and we understand that some of the postings are being delayed through this effort.

Question 4:

Once a formal waiver proposal is prepared and submitted to CMS for discussion and review, does CMS do any kind of follow-up with beneficiaries and providers in the state to determine the impact of the proposed changes?

Answer:

CMS works closely with its state partners to develop demonstration programs that improve access to health care while ensuring access to providers that can serve our beneficiaries' health care needs. Toward that end, CMS requires states to have a public process to solicit input from all interested stakeholders- including the general public, advocacy community, providers, and others. The primary partnership in the Medicaid program as articulated in the Social Security Act is between CMS and the "single state agency" (Medicaid agency). As such, there is no formal process while a proposal is under review for soliciting input directly from providers or beneficiaries, although their comments are always welcomed and considered. Most importantly, we believe that the "upfront" public process we require of our state partners combined with a public posting of demonstration-related documents on the CMS website ensures that all interested parties have the necessary access to information and ability to comment. This is why we have redoubled our efforts to ensure our website is user-friendly and up-to-date.

Question 5:

How many Medicaid and SCHIP waivers have been submitted and approved since CMS last updated the waiver website in September 2004? Please list the states, the date each waiver proposal was submitted to CMS, the date each waiver proposal was approved by CMS, and a detailed description of each waiver.

Answer:

The CMS waiver website is currently up-to-date.

State	Submitted	Description	Approved
Kentucky	6/28/05	Three year extension for its existing section 1115 demonstration projects.	10/25/05
Florida	10/3/05	Medicaid reform demonstration that allows Beneficiaries to choose from a variety of benefit packages.	10/19/05
Arkansas	5/31/05	Three year extension of Arkansas' section 1115 Medicaid demonstration project for family planning services through 9/30/08.	9/30/05
California	7/5/05	1115 Medicaid Demonstration "Medi-Cal Hospital/Uninsured Care" for a 5-year period through 8/31/10.	8/31/05
California	8/26/05	Three month extension to 1115 family planning demonstration entitled Family PACT.	9/12/05
Idaho	12/9/04	Amended the Special Terms and Conditions which will allow Idaho to cover optional categories of pregnant women and parents, as well as childless adults.	6/21/05
New Mexico	4/21/05	Amendment to HIFA demonstration which decreases copayments for the demonstration populations, including parents of Medicaid and SCHIP children and childless adults with incomes up to 200 percent of the FPL.	6/21/05
Oklahoma	1/13/05	SoonerCare HIFA Amendment with premium subsidies.	9/30/05

Rhode Island	7/15/05	Three year extension to Rhode Island's RItecare Demonstration. The extension is for the period August 1, 2005 through July 31, 2008, and allows the State to maintain its current program operations.	8/31/05
Virginia	10/18/04	HIFA waiver which expands coverage to pregnant women over the age of 19 with income between 133 and 200 percent of the FPL. Also redesigns the premium assistance program approved under SCHIP to waive the required minimum employer contribution; wrap-around coverage for benefit packages that do not meet SCHIP requirements; and the 6-month period without coverage under a group health plan.	7/1/05
Katrina 1115 Approvals			
Texas	9/7/05	Hurricane Katrina Relief demonstration.	9/15/05
Alabama	9/16/05	Hurricane Katrina Relief demonstration.	9/22/05
Mississippi	9/16/05	Hurricane Katrina Relief demonstration.	9/22/05
Florida	9/16/05	Hurricane Katrina Relief demonstration.	9/23/05
Idaho	9/22/05	Hurricane Katrina Relief demonstration.	9/27/05
Arkansas	9/23/05	Hurricane Katrina Relief demonstration.	9/28/05
DC	9/23/05	Hurricane Katrina Relief demonstration.	9/28/05
Georgia	9/26/05	Hurricane Katrina Relief demonstration.	9/28/05
Tennessee	9/30/05	Hurricane Katrina Relief demonstration.	10/6/05
Puerto Rico	10/3/05	Hurricane Katrina Relief demonstration.	10/6/05
South Carolina	10/11/05	Hurricane Katrina Relief demonstration.	10/20/05
Indiana	10/12/05	Hurricane Katrina Relief demonstration.	10/20/05

Question 6:

How many waiver applications has CMS disapproved in the last four years? Can you tell me the states where such disapprovals have occurred?

Answer:

State	Submitted	Description	Disapproved
Delaware	5/31/02	SCHIP 1115 HIFA to cover adults with incomes between 65 percent and 185 percent of FPL.	3/19/03
Delaware	12/31/02	Delaware Pharmacy Assistance Program	7/9/03
Indiana	7/11/01	SCHIP 1115 to fund a lead poisoning prevention project to replace windows in targeted low-income neighborhoods.	5/10/02
Indiana	8/31/01	SCHIP 1115 to provide vision and dental services to low income children with health insurance that does not cover these services.	2/25/02
Maryland	7/27/98	1115 Health Choice Amendment to expend Temporary Cash Assistance (TCA) coverage for parents under 21 and for all TCA parents who require substance abuse services in therapeutic communities or group homes to retain Medicaid eligibility when treatment services extend beyond 30 days in an IMD.	1/17/03
Minnesota	6/29/00	1115 Prepaid Medical Assistance Project Plus for Ramsey County	1/16/03
Minnesota	1/4/05	Disapproval of request to allow only one managed care plan in the Rochester area that includes two counties. 42 CFR 438.52 requires at least two plans for each county.	05/03/05
Oregon	9/6/01	Oregon Health Plan II amendment for 6-month eligibility	10/15/02
Oregon	7/13/01	Oregon Health Plan II amendment for coverage of Institutes for Mental Disease.	10/15/02

Question 7:

Mr. Smith, I believe that federal oversight of Medicaid and other entitlement programs must follow a good government model. Government should provide for a fair, uniform rule of law that is transparent, understood and consistently applied. Many states have complained that CMS consistently changes the rules of the game in Medicaid without clearly stating what the new rules are. Those complaints have not abated. States are still concerned that CMS is overseeing Medicaid by a set of rules that is not open and understood by the public, particularly with regard to state plan amendment approvals and intergovernmental transfers. CMS policy now appears to be up-front reviews of state program funding any time a plan amendment is submitted, whether or not that funding is related to the particular state request at hand. There also appears to be an effort to hold relatively minor plan amendments hostage to a broader Administration agenda to slowly hinder states' ability to run their programs. Mr. Smith, can you tell me what mechanisms CMS has in place to ensure consistency and fairness across states?

Answer:

In 2002, we created a new team within the Centers for Medicare & Medicaid Services (CMS) to specifically review state plan amendments that involved reimbursement to institutional providers such as nursing homes and hospitals. In 2003, we created another team to review plans affecting non-institutional providers such as physicians and clinics. In January 2005, the Division of Reimbursement and State Financing (DRSF) in order to consolidate in one CMS component responsibility for all state Medicaid reimbursement policy and state Medicaid financing issues. A central responsibility of this Division is to ensure consistency in the nationwide application of Medicaid reimbursement and financing policy. The Division now comprises three teams which are responsible for institutional reimbursement, non-institutional reimbursement, and state financing policy and oversight. Each of these teams meets internally weekly to discuss reimbursement and state financing proposals.

Since August 2003, CMS has been requesting information from states regarding detail on how they are financing their share of Medicaid program costs under the Medicaid reimbursement State Plan Amendment (SPA) review process. The questions related to state financing are applied consistently and equally to all states under the SPA review process. CMS will not approve new SPA proposals until states have fully explained how they finance their Medicaid programs and until such time that states have agreed to terminate any financing practices that contradict the spirit of the Federal-state partnership. In addition, follow-up audits are conducted for any questionable financing practice that is discovered as part of the Medicaid reimbursement SPA review.

We now have reviewed more than 850 state requests for changes in payment methodologies through SPAs. As of August 12, 2005 26 states have revised their financing arrangements dealing with 62 different provider payments.

Other mechanisms in place to achieve consistency include increased integration of activities with our Regional Offices and the recent hiring of the 100 new Medicaid financial management specialists/accountants. Specifically, we have:

- As of August 12, 2005, hired 99 FTEs to ensure that states are appropriately financing their Medicaid programs in accordance with Federal and regulation and to improve Medicaid financial management oversight. Ninety of the staff are allocated to specific states and 10 of these staff are based in Central Office.
- Held formal 2-week training sessions, in September 2004 and February 2005, to provide an understanding of policy and operations related to Medicaid reimbursement and state financing to new staff.
- Convened two national conferences, one recently held in April 2005 and the other scheduled for September 2005, for financial management staff to exchange information, resolve issues, share best practices and discuss FM reviews and audits.
- Scheduled monthly meetings with each Regional Office, wherein we discuss all pending Medicaid reimbursement proposals and all the Medicaid financial management issues in the respective Regional Office.
- Scheduled monthly teleconferences with all of the new 100 FTEs to discuss specific issues relative to their functions.

Question 8:

What data can you provide to back up your assertion that CMS enforcement policies are uniform and consistent for all states?

Answer:

As of August 12, 2005, CMS has reviewed over 850 Medicaid reimbursement State Plan Amendments under our review process that requires the termination of any funding mechanisms that contradict the intent of the Federal-state partnership. Through this review process, all states are asked a standard series of questions on how they are financing their share of Medicaid program costs. Twenty-six states have agreed to terminate one or more financing practices that contradict the intent of the Federal-state partnership and CMS is working cooperatively with 7 other states with similar financing mechanisms to terminate such arrangements.

Further, the following processes have been instituted:

1. A state plan amendment (SPA) that contains a provision(s) that impacts reimbursement is referred to the Division of Reimbursement and State Financing.

2. The SPA is assigned to an analyst. The questions related to state financing of the Medicaid program (commonly referred to as the "5 funding questions") are submitted to the state. These funding questions are listed in Attachment A.

Attachment A

Five Funding Questions

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers retain all of the Medicaid payments including the Federal and State share (includes normal per diem, DRG, DSH, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization?

If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.) For DSH payments, please also indicate if you are making DSH payments in excess of 100% of costs and the percentage of payments in excess of 100% that are returned to the State, local governmental entity, or any other intermediary organization.

Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the state share of each type of Medicaid payment (normal per diem, DRG, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the state share is being provided through the use local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Does any public provider receive payments that in the aggregate (normal per diem, DRG, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

1. CMS has 90-days in which to approve, disapprove, or request additional information on States' Medicaid reimbursement SPA proposals.
2. States have 90-days in which to respond to CMS's request for additional information. Included in the requests for additional information for all States are the 5 funding questions. CMS has made every effort to assist States in responding to the 5 funding questions including on-going dialogue with State staff and a willingness to meet with State officials to discuss the funding in question and/or to answer any questions the State may have regarding the 5 funding questions. Upon receipt of the States' responses, CMS must either approve or disapprove within 90-days.
3. Some States have chosen to delay final action on a Medicaid reimbursement SPA through the formal withdrawal of the response to CMS's request for additional information. Such action allows a State to preserve its requested effective date under the SPA and allows both parties to work through the issues to achieve resolution in an expeditious manner.
4. If a state refuses to answer the funding questions, CMS will disapprove the SPA by the end of the second 90 day clock.
5. If CMS determines a SPA increases the FMAP and is based on an existing funding arrangement, it requests the state to end such arrangements prospectively in connection with the state's budget cycle.
6. If CMS determines a SPA increases the FMAP and is a new funding arrangement, the SPA is disapproved or the state may withdraw the SPA.

Other mechanisms in place to achieve consistency include increased integration of activities with our Regional Offices and the recent hiring of the 100 new Medicaid financial management specialists/accountants. Specifically, we have:

- As of August 12, 2005, hired 99 FTEs to ensure that states are appropriately financing their Medicaid programs in accordance with Federal and regulation and to improve Medicaid financial management oversight. Ninety of the staff are allocated to specific states and 10 of these staff are based in Central Office.
- Held formal 2-week training sessions, held in September 2004 and February 2005, to provide an understanding of policy and operations related to Medicaid reimbursement and state financing to new staff.
- Convened two national conferences, one recently held in April 2005 and the other scheduled for September 2005, for financial management staff to exchange information, resolve issues, share best practices and discuss FM reviews and audits.

In addition, for each SPA that has terminated an impermissible financing arrangement, through our Regional Offices, we are auditing the impermissible financing arrangement to ensure uniform application and confirm compliance with termination provisions.

Question 9:

Have internal reviews been conducted to determine there are no discrepancies in policy or outcome?

Answer:

The Division of Reimbursement and State Financing was created in order to consolidate in one CMS component responsibility for all state Medicaid reimbursement policy and state Medicaid financing issues. A central responsibility of this Division is to ensure consistency in the nationwide application of Medicaid reimbursement and financing policy. The Division now comprises three Teams which are responsible for institutional reimbursement, non-institutional reimbursement, and state financing policy and oversight.

In addition, for each SPA that has terminated an impermissible financing arrangement, through our Regional Offices, we are performing financial management reviews of impermissible financing arrangements to ensure uniform application and confirm compliance with termination provisions.

Question 10:

What happens to states that are not submitting plan amendments or waivers? Are they exempt from such reviews?

Answer:

There is a multi-tiered strategy for developing, focusing and enhancing CMS resources in the oversight of the Medicaid program. Beginning with FY 2002, CMS developed and institutionalized a structured Regional Office Financial Management (FM) work plan, incorporating an intensive planning process with a consistent and centralized national approach for reviewing states' claims. An integral component of the work plan is identifying areas of high risk and performing focused FM reviews in such areas.

Our current financial management review process is outlined in our work plan for FY 2005 which is attached. For those areas where we have notified the state that there is a concern with their financing of the non-federal share of their Medicaid program, we have instructed our Regional Offices to conduct a financial management review to document issues and develop a course of corrective action.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

(Date Stamped: JAN 25 2005)

TO: All Regional Administrators

FROM: Director
Center for Medicaid and State Operations

SUBJECT: Regional Office (RO) Medicaid/State Children's Health Insurance Program (SCHIP) Financial Management (FM) Workplans for Fiscal Year (FY) 2005--ACTION

This memorandum and attachments describe the regional office (RO) Medicaid and SCHIP Financial Management (FM) Workplans for FY 2005, which you submitted in response to my November 8 request, and which I now ask that you proceed to implement. The national and RO specific FM workplans have been established to address continued concerns which were identified in reports by the General Accounting Office and the Chief Financial Officer. The workplan provides for a structured Medicaid and SCHIP FM review process, with particular emphasis on on-site FM reviews in high risk areas of states' programs. In keeping with that emphasis, we have established, and the attached FY 2005 workplans incorporate, a standard of at least one significant FM review per FTE per fiscal year. Accordingly, your individual RO workplans reflect this standard. We expect that you will commit the staffing and travel resources necessary to successfully carry out the work reflected in your approved FY 2005 FM Workplan.

As you know, the FM Workplan process has two parts. Step One is development of the Workplan itself, which is based on the Center for Medicaid and State Operations' (CMSO) review of your submissions. After CMSO's review of the RO proposed workplans, and incorporation of any revisions that you and we agree are appropriate, CMSO compiles the national and RO-specific FM Workplan (which is attached for FY 2005).

Step Two of the Workplan process is to track FM activities and accomplishments throughout the FY. Following the end of each quarter, you will be asked to submit a quarterly FM Activities Report (FMAR). The format will be the same as the basic FM Workplan, as shown in the attachments to this memorandum. The FM personnel costs, however, will be reported only on the fourth quarterly report, for the entire fiscal year.

Additionally, the FMAR includes a column for ROs to provide narrative information for four key FM activity line items: Cost Allocation Plans (Line 1), Administrative Claiming Plans (Line 2), Focused Financial Management Reviews (Line 9), and On-site Quarterly Expenditure Reviews (Line 14A). The FMAR is due 30 days after the end of each quarter. Accordingly, the report for the quarter ending December 31, 2004, will be due by January 30, 2005.

We recognize that it may be necessary to revise the National or RO specific workplans, based on current events or a need to redeploy resources. Any requests by a RO to revise the FM workplan should be submitted by the Associate Regional Administrator to Edward Gendron, for review and approval, with a copy to Richard Strauss.

If there are questions about this request, please contact me or ask your staff to contact Richard Strauss at (410) 786-2019.

Sincerely,

/s/

Dennis G. Smith

Attachments

cc:
Associate Regional Administrators
  Division of Medicaid and State Operations

RO FM Branch Chiefs

Attachment 1

NATIONAL AND RO SPECIFIC MEDICAID/SCHIP FM WORKPLANS FOR FY 2005

The following provides a brief description of the attached Excel spreadsheet (FY2005FMWPlan1.xls) containing the national (worksheet: "National FM Workplan") and RO specific (worksheet: "RO xx") FY 2005 RO FM Workplan. On each of the attached RO specific workplans the cells in which information was provided by the ROs are highlighted in pale yellow. The information is presented under 15 FM activity line items, which are grouped under 3 overall categories (I. Front – End Financial Management, II. Ongoing FM Oversight/Enforcement and III. Quarterly Reviews). Each RO provided the indicated information; this information has been compiled into the national and RO specific workplans for FY 2005.

- Column A - Financial Management Activities. Column A briefly describes the 15 FM activity line item categories.

- Column B - Total Full-Time Equivalents (FTEs). Each RO entered at the top of Column B the total non-supervisory FTEs projected to be working on the FM activities during the fiscal year. Each RO entered on each indicated FM activity line item in Column B the level of FTEs projected to be working on that activity during the fiscal year. The Grand Total All Areas of the RO entries on each line is calculated at the bottom of Column B. In order to assure proper entry by the ROs on each line, the Grand Total All Entries calculated from the entries on each line must equal the total entered at the top of the column; if it does not, the word "ERROR" will be displayed in the Grand Total.

- Column C - Percent of Total FTEs. The percentage on each line of Column C is automatically calculated based upon the data entered in Column B; it is equal to the FTE level for each line of Column B divided by the grand total for all FTEs at the bottom of Column B.

- Column D - Number of Activities Completed. Each RO entered on each FM activity line item of Column D the projected number of such activities to be completed during the fiscal year.

- Column E - Activities Per FTE. The entry on each activity line item in Column E is automatically calculated; it is equal to the number of activities completed and entered in Column D divided by the number of FTEs entered in Column B.

- Column F - Personnel Cost Per Activity. Each RO entered at the top of Column F the total projected personnel costs for the fiscal year. The entry for personnel costs on each FM activity line item in Column F is automatically calculated by multiplying the percentages calculated in Column C by the total projected costs entered at the top of Column F.

- Column G - Travel Cost Per Activity. Each RO entered at the top of Column G the total projected travel costs for each FM activity line item for the fiscal year. Each RO entered on each indicated FM activity line item in Column G the travel costs projected for that activity during the fiscal year. The Grand Total All Areas of the RO entries on each line is calculated at the bottom of Column G. In order to assure proper entry by the ROs on each line, the Grand Total All Entries calculated from the entries on each line must equal the total entered at the top of the column; if it does not, the word "ERROR" will be displayed in the Grand Total.

The National FM Workplan, the RO specific workplan worksheets, and the other worksheets contained in the attached Excel file (file: FY2005FMWorkPlan1.xls), are briefly described below:

- Worksheet: NATIONAL FM WORKPLAN. This worksheet is a summary compilation of the RO specific workplans. The columns of this worksheet are described above.
- Worksheet: NO. of Activities. This worksheet is a breakout of Column D (Number of Activities Completed), by RO, from the National workplan.
- Worksheet: FTEs. This worksheet is a breakout of Column B (Total FTEs), by RO, from the National workplan.
- Worksheet: RO xx. There are ten of these worksheets, representing one for each of the ROs, which reflect the RO workplan submittals. The columns of this worksheet are described above.

Also attached, is an Excel file (file: 2005FMReviews.xls) which provides by State and subject category, the projected focused FM reviews projected for FY 2005. There are two worksheets in this file:

- Worksheet: ALPHABETIC. This worksheet orders the States alphabetically in presenting the focused FM reviews.
- Worksheet: RO. This worksheet orders the States by RO in presenting the focused FM reviews.

Attachments (Excel files):
FY2005FMWorkPlan1.xls
2005FMReviews.xls

FY 2005 FM WORKPLAN - FOCUSED REVIEWS

STATE	TOTAL	Family Planning Claims	IGTs	Insurance Reimbsmt.	Pharmacy Benefit Manager	Transpt. Costs	TCM Services	DSH Payments	Nursing Salary Costs	Undocumented Aliens	SCHIP	Non MMIS Claims	SPMP	Nursing Home Assmt.	Hospital Reimbsmt.	Mental Health Rehab Services	MCO	Contract Costs	FQHC	UPL	Enhanced Payments
Alabama	1		1																		
Alaska	2																				
Arizona	1																				
Arkansas	1										1										
California	3						1														
Colorado	2														1	1					
Connecticut	1	1																			
Delaware	-																				
District of Columbia	1															1					
Florida	1																			1	
Georgia	-																				
Hawaii	1																				
Idaho	1	1																			
Illinois	1																	1			
Indiana	2																			1	
Iowa	-																				
Kansas	2																				
Kentucky	1																				1
Louisiana	2							1											1		
Maine	-																				
Maryland	1																1				
Massachusetts	2			1		1															
Michigan	2																				
Minnesota	1		1																		
Mississippi	1		1																		
Missouri	2																				
Montana	-																				
Nebraska	1																				
Nevada	1												1								
New Hampshire	1				1																
New Jersey	3	1						1	1												
New Mexico	1																				
New York	6									1	1	1	1	1	1						
North Carolina	1																				
North Dakota	-																				
Ohio	2																				
Oklahoma	1																				
Oregon	1																				
Pennsylvania	1																	1			
Rhode Island	1					1															
South Carolina	1																				
South Dakota	-																				
Tennessee	1																				
Texas	1																				
Utah	1						1														
Vermont	1						1														
Virginia	-																				
Washington	1									1											
West Virginia	1																		1		
Wisconsin	2																				
Wyoming	-																				
TOTAL	61	3	3	1	1	2	3	2	1	2	2	1	2	1	2	2	1	2	2	2	1

Doc: 2005FMReviews.xls
Date Last Revised: 12/15/2004
Worksheet: ALPHABETIC

FY 2005 FM WORKPLAN - FOCUSED REVIEWS

STATE	Provider Overpymts.	Source of Funds	Admin Claims	IP Hospital Services	School Based Claims	APD Claims	Nurse Aide Training Costs	Prior Approval/ Equipment Purchases	HCBS Waiver	High Cost Case Mgmt.	High Volume Provider Pymts.	Parent Fee Program	Juvenile Delinquent/ Detention Center	LTC Institutional Reimbsmt.	CPEs	MMIS	OP Hospital Services	Personal Care Services	Indian HS Facilities/ Non-Native
Alabama																			
Alaska																		1	1
Arizona			1																
Arkansas																			
California	1																1		
Colorado																			
Connecticut																			
Delaware																			
District of Columbia																			
Florida																			
Georgia																			
Hawaii				1															
Idaho																			
Illinois																			
Indiana			1																
Iowa																			
Kansas												1	1						
Kentucky																			
Louisiana																			
Maine																			
Maryland																			
Massachusetts																			
Michigan					1	1													
Minnesota																			
Mississippi																			
Missouri														1	1				
Montana																			
Nebraska																1			
Nevada																			
New Hampshire																			
New Jersey																			
New Mexico	1																		
New York																			
North Carolina	1																		
North Dakota																			
Ohio							1	1											
Oklahoma	1																		
Oregon	1																		
Pennsylvania																			
Rhode Island																			
South Carolina		1																	
South Dakota																			
Tennessee			1																
Texas											1								
Utah																			
Vermont																			
Virginia																			
Washington																			
West Virginia																			
Wisconsin									1	1									
Wyoming																			
TOTAL	5	1	3	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

Doc: 2005FMReviews.xls
Date Last Revised: 12/15/0
Worksheet: ALPHABETIC

FY 2005 FM WORKPLAN - FOCUSED REVIEWS

STATE	TOTAL	Family Planning Claims	IGTs	Insurance Reimbsmt.	Pharmacy Benefit Manager	Transpt. Costs	TCM Services	DSH Payments	Nursing Salary Costs	Undocumented Aliens
Connecticut	1	1	-	-	-	-	-	-	-	-
Maine	-	-	-	-	-	-	-	-	-	-
Massachusetts	2	-	-	1	-	1	-	-	-	-
New Hampshire	1	-	-	-	1	-	-	-	-	-
Rhode Island	1	-	-	-	-	1	-	-	-	-
Vermont	1	-	-	-	-	-	1	-	-	-
TOTAL RO 1	6	1	-	1	1	2	1	-	-	-
New Jersey	3	1	-	-	-	-	-	1	1	-
New York	6	-	-	-	-	-	-	-	-	1
TOTAL RO 2	9	1	-	-	-	-	-	1	1	1
Delaware	-	-	-	-	-	-	-	-	-	-
District of Columbia	1	-	-	-	-	-	-	-	-	-
Maryland	1	-	-	-	-	-	-	-	-	-
Pennsylvania	1	-	-	-	-	-	-	-	-	-
Virginia	-	-	-	-	-	-	-	-	-	-
West Virginia	1	-	-	-	-	-	-	-	-	-
TOTAL RO 3	4	-	-	-	-	-	-	-	-	-
Alabama	1	-	1	-	-	-	-	-	-	-
Florida	1	-	-	-	-	-	-	-	-	-
Georgia	-	-	-	-	-	-	-	-	-	-
Kentucky	1	-	-	-	-	-	-	-	-	-
Mississippi	1	-	1	-	-	-	-	-	-	-
North Carolina	1	-	-	-	-	-	-	-	-	-
South Carolina	1	-	-	-	-	-	-	-	-	-
Tennessee	1	-	-	-	-	-	-	-	-	-
TOTAL RO 4	7	-	2	-	-	-	-	-	-	-
Illinois	1	-	-	-	-	-	-	-	-	-
Indiana	2	-	-	-	-	-	-	-	-	-
Michigan	2	-	-	-	-	-	-	-	-	-
Minnesota	1	-	1	-	-	-	-	-	-	-
Ohio	2	-	-	-	-	-	-	-	-	-
Wisconsin	2	-	-	-	-	-	-	-	-	-
TOTAL RO 5	10	-	1	-	-	-	-	-	-	-
Arkansas	1	-	-	-	-	-	-	-	-	-
Louisiana	2	-	-	-	-	-	-	1	-	-
New Mexico	1	-	-	-	-	-	-	-	-	-
Oklahoma	1	-	-	-	-	-	-	-	-	-
Texas	1	-	-	-	-	-	-	-	-	-
TOTAL RO 6	6	-	-	-	-	-	-	1	-	-
Iowa	-	-	-	-	-	-	-	-	-	-
Kansas	2	-	-	-	-	-	-	-	-	-
Missouri	2	-	-	-	-	-	-	-	-	-
Nebraska	1	-	-	-	-	-	-	-	-	-
TOTAL RO 7	5	-	-	-	-	-	-	-	-	-
Colorado	2	-	-	-	-	-	-	-	-	-
Montana	-	-	-	-	-	-	-	-	-	-
North Dakota	-	-	-	-	-	-	-	-	-	-
South Dakota	-	-	-	-	-	-	-	-	-	-
Utah	1	-	-	-	-	-	1	-	-	-
Wyoming	-	-	-	-	-	-	-	-	-	-
TOTAL RO 8	3	-	-	-	-	-	1	-	-	-
Arizona	1	-	-	-	-	-	-	-	-	-
California	3	-	-	-	-	-	1	-	-	-
Hawaii	1	-	-	-	-	-	-	-	-	-
Nevada	1	-	-	-	-	-	-	-	-	-
TOTAL RO 9	6	-	-	-	-	-	1	-	-	-
Alaska	2	-	-	-	-	-	-	-	-	-
Idaho	1	1	-	-	-	-	-	-	-	-
Oregon	1	-	-	-	-	-	-	-	-	-
Washington	1	-	-	-	-	-	-	-	-	1
TOTAL RO 10	5	1	-	-	-	-	-	-	-	1
TOTAL ALL ROs	61	3	3	1	1	2	3	2	1	2

Doc: 2005FMReviews.xls
Date Last Revised: 12/15/2004
Worksheet: RO

FY 2005 FM WORKPLAN - FOCUSED REVIEWS

STATE	SCHIP	Non MMIS Claims	SPMP	Nursing Home Assmt.	Hospital Reimbsmt.	Mental Health Rehab Services	MCO	Contract Costs	FQHC	UPL	Enhanced Payments
Connecticut	-	-	-	-	-	-	-	-	-	-	-
Maine	-	-	-	-	-	-	-	-	-	-	-
Massachusetts	-	-	-	-	-	-	-	-	-	-	-
New Hampshire	-	-	-	-	-	-	-	-	-	-	-
Rhode Island	-	-	-	-	-	-	-	-	-	-	-
Vermont	-	-	-	-	-	-	-	-	-	-	-
TOTAL RO 1	-	-	-	-	-	-	-	-	-	-	-
New Jersey	-	-	-	-	-	-	-	-	-	-	-
New York	1	1	1	1	1	-	-	-	-	-	-
TOTAL RO 2	1	1	1	1	1	-	-	-	-	-	-
Delaware	-	-	-	-	-	-	-	-	-	-	-
District of Columbia	-	-	-	-	-	1	-	-	-	-	-
Maryland	-	-	-	-	-	-	1	-	-	-	-
Pennsylvania	-	-	-	-	-	-	-	1	-	-	-
Virginia	-	-	-	-	-	-	-	-	-	-	-
West Virginia	-	-	-	-	-	-	-	-	1	-	-
TOTAL RO 3	-	-	-	-	-	1	1	1	1	-	-
Alabama	-	-	-	-	-	-	-	-	-	-	-
Florida	-	-	-	-	-	-	-	-	-	1	-
Georgia	-	-	-	-	-	-	-	-	-	-	-
Kentucky	-	-	-	-	-	-	-	-	-	-	1
Mississippi	-	-	-	-	-	-	-	-	-	-	-
North Carolina	-	-	-	-	-	-	-	-	-	-	-
South Carolina	-	-	-	-	-	-	-	-	-	-	-
Tennessee	-	-	-	-	-	-	-	-	-	-	-
TOTAL RO 4	-	-	-	-	-	-	-	-	-	1	1
Illinois	-	-	-	-	-	-	-	1	-	-	-
Indiana	-	-	-	-	-	-	-	-	-	1	-
Michigan	-	-	-	-	-	-	-	-	-	-	-
Minnesota	-	-	-	-	-	-	-	-	-	-	-
Ohio	-	-	-	-	-	-	-	-	-	-	-
Wisconsin	-	-	-	-	-	-	-	-	-	-	-
TOTAL RO 5	-	-	-	-	-	-	-	1	-	1	-
Arkansas	1	-	-	-	-	-	-	-	-	-	-
Louisiana	-	-	-	-	-	-	-	-	1	-	-
New Mexico	-	-	-	-	-	-	-	-	-	-	-
Oklahoma	-	-	-	-	-	-	-	-	-	-	-
Texas	-	-	-	-	-	-	-	-	-	-	-
TOTAL RO 6	1	-	-	-	-	-	-	-	1	-	-
Iowa	-	-	-	-	-	-	-	-	-	-	-
Kansas	-	-	-	-	-	-	-	-	-	-	-
Missouri	-	-	-	-	-	-	-	-	-	-	-
Nebraska	-	-	-	-	-	-	-	-	-	-	-
TOTAL RO 7	-	-	-	-	-	-	-	-	-	-	-
Colorado	-	-	-	-	1	1	-	-	-	-	-
Montana	-	-	-	-	-	-	-	-	-	-	-
North Dakota	-	-	-	-	-	-	-	-	-	-	-
South Dakota	-	-	-	-	-	-	-	-	-	-	-
Utah	-	-	-	-	-	-	-	-	-	-	-
Wyoming	-	-	-	-	-	-	-	-	-	-	-
TOTAL RO 8	-	-	-	-	1	1	-	-	-	-	-
Arizona	-	-	-	-	-	-	-	-	-	-	-
California	-	-	-	-	-	-	-	-	-	-	-
Hawaii	-	-	-	-	-	-	-	-	-	-	-
Nevada	-	-	1	-	-	-	-	-	-	-	-
TOTAL RO 9	-	-	1	-	-	-	-	-	-	-	-
Alaska	-	-	-	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	-	-	-	-	-	-
Oregon	-	-	-	-	-	-	-	-	-	-	-
Washington	-	-	-	-	-	-	-	-	-	-	-
TOTAL RO 10	-	-	-	-	-	-	-	-	-	-	-
TOTAL ALL ROs	2	1	2	1	2	2	1	2	2	2	1

Doc: 2005FMReviews.xls
Date Last Revised: 12/15/2004
Worksheet: RO

FY 2005 FM WORKPLAN - FOCUSED REVIEWS

STATE	Provider Overpymts.	Source of Funds	Admin Claims	IP Hospital Services	School Based Claims	APD Claims	Nurse Aide Training Costs	Prior Approval/ Equipment Purchases	HCBS Waiver	High Cost Case Mgmt.
Connecticut	-	-	-	-	-	-	-	-	-	-
Maine	-	-	-	-	-	-	-	-	-	-
Massachusetts	-	-	-	-	-	-	-	-	-	1
New Hampshire	-	-	-	-	-	-	-	-	-	-
Rhode Island	-	-	-	-	-	-	-	-	-	-
Vermont	-	-	-	-	-	-	-	-	-	-
TOTAL RO 1	-	-	-	-	-	-	-	-	-	1
New Jersey	-	-	-	-	-	-	-	-	-	-
New York	-	-	-	-	-	-	-	-	-	-
TOTAL RO 2	-	-	-	-	-	-	-	-	-	-
Delaware	-	-	-	-	-	-	-	-	-	-
District of Columbia	-	-	-	-	-	-	-	-	-	-
Maryland	-	-	-	-	-	-	-	-	-	-
Pennsylvania	-	-	-	-	-	-	-	-	-	-
Virginia	-	-	-	-	-	-	-	-	-	-
West Virginia	-	-	-	-	-	-	-	-	-	-
TOTAL RO 3	-	-	-	-	-	-	-	-	-	-
Alabama	-	-	-	-	-	-	-	-	-	-
Florida	-	-	-	-	-	-	-	-	-	-
Georgia	-	-	-	-	-	-	-	-	-	-
Kentucky	-	-	-	-	-	-	-	-	-	-
Mississippi	-	-	-	-	-	-	-	-	-	
North Carolina	1	-	-	-	-	-	-	-	-	-
South Carolina	-	1	-	-	-	-	-	-	-	-
Tennessee	-	-	1	-	-	-	-	-	-	-
TOTAL RO 4	1	1	1	-	-	-	-	-	-	-
Illinois	-	-	-	-	-	-	-	-	-	-
Indiana	-	-	1	-	-	-	-	-	-	-
Michigan	-	-	-	-	1	1	-	-	-	-
Minnesota	-	-	-	-	-	-	-	-	-	-
Ohio	-	-	-	-	-	-	1	1	-	-
Wisconsin	-	-	-	-	-	-	-	-	1	-
TOTAL RO 5	-	-	1	-	1	1	1	1	1	-
Arkansas	-	-	-	-	-	1	-	-	-	-
Louisiana	-	-	-	-	-	-	-	-	-	-
New Mexico	1	-	-	-	-	-	-	-	-	-
Oklahoma	1	-	-	-	-	-	-	-	-	-
Texas	-	-	-	-	-	-	-	-	-	-
TOTAL RO 6	2	-	-	-	-	1	-	-	-	-
Iowa	-	-	-	-	-	-	-	-	-	-
Kansas	-	-	-	-	-	-	-	-	-	-
Missouri	-	-	-	-	-	-	-	-	-	-
Nebraska	-	-	-	-	-	-	-	-	-	-
TOTAL RO 7	-	-	-	-	-	-	-	-	-	-
Colorado	-	-	-	-	-	-	-	-	-	-
Montana	-	-	-	-	-	-	-	-	-	-
North Dakota	-	-	-	-	-	-	-	-	-	-
South Dakota	-	-	-	-	-	-	-	-	-	-
Utah	-	-	-	-	-	-	-	-	-	-
Wyoming	-	-	-	-	-	-	-	-	-	-
TOTAL RO 8	-	-	-	-	-	-	-	-	-	-
Arizona	-	-	1	-	-	-	-	-	-	-
California	1	-	-	-	-	-	-	-	-	-
Hawaii	-	-	-	1	-	-	-	-	-	-
Nevada	-	-	-	-	-	-	-	-	-	-
TOTAL RO 9	1	-	1	1	-	-	-	-	-	-
Alaska	-	-	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	-	-	-	-	-
Oregon	1	-	-	-	-	-	-	-	-	-
Washington	-	-	-	-	-	-	-	-	-	-
TOTAL RO 10	1	-	-	-	-	-	-	-	-	-
TOTAL ALL ROs	5	1	3	1	1	2	1	1	1	1

Doc: 2005FMReviews.xls
Date Last Revised: 12/15/2004
Worksheet: RO

FY 2005 FM WORKPLAN - FOCUSED REVIEWS

STATE	High Volume Provider Pymts.	Parent Fee Program	Juvenile Delinquents/ Detention Centers	LTC Institutional Reimbsmt.	CPEs	MMIS	OP Hospital Services	Personal Care Services	Indian HS Facilities/ Non Native	RO
Connecticut	-	-	-	-	-	-	-	-	-	1
Maine	-	-	-	-	-	-	-	-	-	1
Massachusetts	-	-	-	-	-	-	-	-	-	1
New Hampshire	-	-	-	-	-	-	-	-	-	1
Rhode Island	-	-	-	-	-	-	-	-	-	1
Vermont	-	-	-	-	-	-	-	-	-	1
TOTAL RO 1	-	-	-	-	-	-	-	-	-	
New Jersey	-	-	-	-	-	-	-	-	-	2
New York	-	-	-	-	-	-	-	-	-	2
TOTAL RO 2	-	-	-	-	-	-	-	-	-	
Delaware	-	-	-	-	-	-	-	-	-	3
District of Columbia	-	-	-	-	-	-	-	-	-	3
Maryland	-	-	-	-	-	-	-	-	-	3
Pennsylvania	-	-	-	-	-	-	-	-	-	3
Virginia	-	-	-	-	-	-	-	-	-	3
West Virginia	-	-	-	-	-	-	-	-	-	3
TOTAL RO 3	-	-	-	-	-	-	-	-	-	
Alabama	-	-	-	-	-	-	-	-	-	4
Florida	-	-	-	-	-	-	-	-	-	4
Georgia	-	-	-	-	-	-	-	-	-	4
Kentucky	-	-	-	-	-	-	-	-	-	4
Mississippi	-	-	-	-	-	-	-	-	-	4
North Carolina	-	-	-	-	-	-	-	-	-	4
South Carolina	-	-	-	-	-	-	-	-	-	4
Tennessee	-	-	-	-	-	-	-	-	-	4
TOTAL RO 4	-	-	-	-	-	-	-	-	-	
Illinois	-	-	-	-	-	-	-	-	-	5
Indiana	-	-	-	-	-	-	-	-	-	5
Michigan	-	-	-	-	-	-	-	-	-	5
Minnesota	-	-	-	-	-	-	-	-	-	5
Ohio	-	-	-	-	-	-	-	-	-	5
Wisconsin	-	-	-	-	-	-	-	-	-	5
TOTAL RO 5	-	-	-	-	-	-	-	-	-	
Arkansas	-	-	-	-	-	-	-	-	-	6
Louisiana	-	-	-	-	-	-	-	-	-	6
New Mexico	-	-	-	-	-	-	-	-	-	6
Oklahoma	-	-	-	-	-	-	-	-	-	6
Texas	1	-	-	-	-	-	-	-	-	6
TOTAL RO 6	1	-	-	-	-	-	-	-	-	
Iowa	-	-	-	-	-	-	-	-	-	7
Kansas	-	1	1	-	-	-	-	-	-	7
Missouri	-	-	-	1	1	-	-	-	-	7
Nebraska	-	-	-	-	-	1	-	-	-	7
TOTAL RO 7	1	1	1	1	1	1	-	-	-	
Colorado	-	-	-	-	-	-	-	-	-	8
Montana	-	-	-	-	-	-	-	-	-	8
North Dakota	-	-	-	-	-	-	-	-	-	8
South Dakota	-	-	-	-	-	-	-	-	-	8
Utah	-	-	-	-	-	-	-	-	-	8
Wyoming	-	-	-	-	-	-	-	-	-	8
TOTAL RO 8	-	-	-	-	-	-	-	-	-	
Arizona	-	-	-	-	-	-	-	-	-	9
California	-	-	-	-	-	-	1	-	-	9
Hawaii	-	-	-	-	-	-	-	-	-	9
Nevada	-	-	-	-	-	-	-	-	-	9
TOTAL RO 9	-	-	-	-	-	-	1	-	-	
Alaska	-	-	-	-	-	-	-	1	1	10
Idaho	-	-	-	-	-	-	-	-	-	10
Oregon	-	-	-	-	-	-	-	-	-	10
Washington	-	-	-	-	-	-	-	-	-	10
TOTAL RO 10	-	-	-	-	-	-	-	1	1	
TOTAL ALL ROs	2	1	1	1	1	1	1	1	1	

Doc: 2005FMReviews.xls
Date Last Revised: 12/15/2004
Worksheet: RO

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005						
Region (Enter I - X):	I-X					SUMMARY FOR RO I-X
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO I-X =	Percent of Total FTEs RO I-X	Number Of Activities Completed RO I-X	FTE Per Activity RO I-X	Personnel Cost Per Activity TOTAL for RO I-X	Travel Cost Per Activity TOTAL for RO I-X
	62.42				$5,073,094.00	$197,897.65
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	2.31	3.70%	119	0.20	$169,561.96	$22.05
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	1.32	2.11%	39	0.23	$108,487.52	$1,663.78
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.91	1.48%	114	0.07	$73,623.57	$6,257.25
4. Financial Administrative Policy Technical Assistance	2.59	4.15%	878	0.03	$212,211.53	$1,052.46
SUBTOTAL I.A.	7.14	11.43%	NA	NA	$583,684.58	$8,995.54
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	1.95	3.13%	207	0.10	$162,430.48	$891.86
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	2.02	3.24%	143	0.19	$165,348.06	$2,268.80
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	1.85	2.97%	122	0.24	$151,863.06	$6,316.77
8. Financial Program Policy Technical Assistance	4.07	8.52%	1176	0.04	$334,359.50	$2,009.01
SUBTOTAL I.B.	9.69	15.85%	NA	NA	$814,001.10	$11,486.43
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	9.91	15.88%	63	1.27	$799,194.28	$64,717.06
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	1.91	3.06%	69	0.30	$155,961.46	$3,086.10
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	4.23	6.76%	163	0.22	$340,581.77	$4,621.79
12. Deferrals and Disallowances	4.19	8.71%	153	0.26	$337,953.36	$2,207.50
13. Financial Data & Information Gathering (e.g., UPL, schools)	4.49	7.20%	823	0.05	$364,960.63	$2,146.25
SUBTOTAL II.	24.73	39.62%	NA	NA	$1,998,651.49	$76,780.70
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	11.76	16.84%	191	0.53	$941,693.38	$80,175.22
B. Desk Reviews In Regional Office	4.15	6.64%	153	0.36	$350,323.19	$1,021.76
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	2.84	4.55%	153	0.18	$226,402.85	$19,022.43
B. Desk Reviews in Regional Office	1.91	3.06%	174	0.11	$158,137.42	$215.56
SUBTOTAL III.	20.66	33.10%	NA	NA	$1,676,556.84	$100,434.97
GRAND TOTAL ALL AREAS	62.42	100.00%	NA	NA	$5,073,094.00	$197,697.65

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005						
Region (Enter I - X):	I					SUMMARY FOR RO I
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO I =	Percent of Total FTEs RO I	Number Of Activities Completed RO I	FTE Per Activity RO I	Personnel Cost Per Activity TOTAL for RO I	Travel Cost Per Activity TOTAL for RO I
	7.00				$504,110.00	$6,000.00
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.14	2.05%	9	0.02	$12,196.71	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.08	1.11%	9	0.01	$6,790.10	$43.23
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.02	0.21%	0	ne	$1,273.14	$0.00
4. Financial Administrative Policy Technical Assistance	0.34	4.61%	52	0.01	$26,558.72	$444.51
SUBTOTAL I.A.	0.56	6.22%	NA	NA	$48,618.66	$487.74
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.11	1.51%	2	0.05	$6,956.56	$34.50
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.16	2.64%	29	0.01	$15,687.24	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.15	2.15%	5	0.03	$12,705.00	$0.00
8. Financial Program Policy Technical Assistance	0.53	7.57%	74	0.01	$44,909.23	$707.61
SUBTOTAL I.B.	0.97	13.88%		NA	$82,438.12	$742.11
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	1.14	16.35%	7	0.16	$97,111.09	$2,514.60
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.31	4.38%	3	0.10	$25,687.24	$0.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.62	8.87%	24	0.03	$52,674.16	$60.69
12. Deferrals and Disallowances	0.26	4.00%	25	0.01	$23,705.33	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.96	13.72%	170	0.01	$81,403.27	$0.00
SUBTOTAL II.	3.31	47.26%	NA	NA	$280,921.10	$2,575.49
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	1.15	16.36%	38	0.03	$97,163.24	$894.00
B. Desk Reviews in Regional Office	0.46	6.51%	10	0.05	$36,697.18	$1,021.76
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.35	4.96%	36	0.01	$29,494.46	$63.33
B. Desk Reviews in Regional Office	0.20	2.79%	10	0.02	$16,557.22	$215.50
SUBTOTAL III.	2.14	30.62%	NA	NA	$181,932.12	$2,194.65
GRAND TOTAL ALL AREAS	7.00	100.00%	NA	NA	$504,110.00	$8,000.00

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005						
REGION (ENTER I - X):	II					SUMMARY FOR RO II
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO II =	Percent of Total FTEs	Number Of Activities Completed RO II	FTE Per Activity RO II	Personnel Cost Per Activity TOTAL for RO II	Travel Cost Per Activity TOTAL for RO II
	9.00	RO II			$698,615.00	$4,500.00
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.38	4.00%	15	0.02	$27,944.60	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.02	0.22%	0	na	$1,552.48	$0.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.00	0.00%	0	na	na	$0.00
4. Financial Administrative Policy Technical Assistance	0.16	1.78%	68	0.00	$12,419.82	$0.00
SUBTOTAL I.A.	0.54	6.00%	83	NA	$41,916.90	$0.00
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.00	0.00%	0	na	na	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.09	1.00%	8	0.01	$6,986.15	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.16	1.78%	2	0.08	$12,419.82	$1,485.00
8. Financial Program Policy Technical Assistance	0.15	1.67%	28	0.01	$11,643.58	$0.00
SUBTOTAL I.B.	0.40	4.44%	38	NA	$31,049.56	$1,485.00
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	1.13	12.56%	10	0.11	$87,714.99	$450.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.18	2.00%	6	0.03	$13,972.30	$2,565.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.75	8.33%	15	0.05	$58,217.92	$0.00
12. Deferrals and Disallowances	0.95	10.56%	34	0.03	$73,742.69	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.75	8.33%	122	0.01	$58,217.92	$0.00
SUBTOTAL II.	3.76	41.78%	187	NA	$291,865.82	$3,015.00
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	2.50	27.78%	18	0.16	$194,059.72	$0.00
B. Desk Reviews in Regional Office	0.50	5.56%	8	0.06	$38,811.94	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	1.10	12.22%	16	0.07	$85,386.28	$0.00
B. Desk Reviews in Regional Office	0.20	2.22%	8	0.03	$15,524.78	$0.00
SUBTOTAL III.	4.30	47.78%	48	NA	$333,782.72	$0.00
GRAND TOTAL ALL AREAS	9.00	100.00%	356	NA	$698,615.00	4,500.00

CURRENT REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT ACTIVITIES--FOR FY 2005						
Region III:	III					SUMMARY FOR RO III
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	Total FTEs For RO III =	Percent of Total FTEs RO III	Number Of Activities Completed RO III	FTE Per Activity RO III	Personnel Cost Per Activity Total for RO III	Travel Cost Per Activity RO III
	3.75				$275,220.00	$11,131.00
I. Front-End Financial Management						
A. Administrative Program Development						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.09	2.40%	7	0.01	$6,605.28	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.06	1.60%	3	0.02	$4,403.52	$0.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.02	0.53%	2	0.01	$1,467.84	$0.00
4. Financial Administrative Policy Technical Assistance	0.28	7.47%	107	0.00	$20,549.76	$0.00
SUBTOTAL I.A.	0.45	12.00%	119	NA	$33,026.40	$0.00
B. Services Program Development						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.00	0.00%	0		$0.00	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.07	1.87%	4	0.02	$5,137.44	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.23	6.13%	6	0.04	$16,880.18	$0.00
8. Financial Program Policy Technical Assistance	0.40	10.67%	116	0.00	$29,356.80	$0.00
SUBTOTAL I.B.	0.70	18.67%	126	NA	$51,374.40	$0.00
II. Ongoing FM Oversight/Enforcement						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	0.48	12.80%	4	0.12	$35,228.16	$3,950.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.33	8.80%	10	0.03	$24,219.36	$500.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.26	6.93%	16	0.02	$19,081.92	$0.00
12. Deferrals and Disallowances	0.12	3.20%	6	0.02	$8,807.04	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.42	11.20%	81	0.01	$30,824.64	$0.00
SUBTOTAL II.	1.61	42.93%	97	NA	$118,161.12	$4,450.00
III. Quarterly Reviews						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	0.75	20.00%	10	0.08	$55,044.00	$6,681.00
B. Desk Reviews In Regional Office	0.13	3.47%	38	0.00	$9,540.96	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.00	0.00%	0	na	$0.00	$0.00
B. Desk Reviews In Regional Office	0.11	2.93%	48	0.00	$6,073.12	$0.00
SUBTOTAL III.	0.99	26.40%	96	NA	$72,658.08	$6,681.00
GRAND TOTAL ALL AREAS	3.75	100.00%	438	NA	$275,220.00	$11,131.00

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005

REGION (ENTER I - X):	IV					SUMMARY FOR RO IV
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO IV =	Percent of Total FTEs RO IV	Number Of Activities Completed RO IV	FTE Per Activity RO IV	Personnel Cost Per Activity TOTAL for RO IV	Travel Cost Per Activity TOTAL for RO IV
	7.92				$612,861.00	$30,400.00
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.13	1.64%	4	0.03	$10,059.59	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.22	2.78%	0	na	$17,023.92	$0.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.32	4.04%	38	0.01	$24,762.08	$0.00
4. Financial Administrative Policy Technical Assistance	0.37	4.67%	51	0.01	$28,631.13	$0.00
SUBTOTAL I.A.	1.04	13.13%	NA	NA	$80,476.70	$0.00
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.38	4.80%	46	0.01	$29,404.95	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.35	4.42%	22	0.02	$27,083.50	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.41	5.18%	24	0.02	$31,728.39	$600.00
8. Financial Program Policy Technical Assistance	0.87	10.98%	183	0.00	$67,321.85	$800.00
SUBTOTAL I.B.	2.01	25.38%	NA	NA	$155,538.89	$1,200.00
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	1.25	15.78%	8	0.16	$96,726.80	$11,200.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.25	3.18%	23	0.01	$19,345.36	$0.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.33	4.17%	13	0.03	$25,535.88	$0.00
12. Deferrals and Disallowances	0.37	4.87%	5	0.07	$28,831.13	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.49	8.19%	74	0.01	$37,916.91	$0.00
SUBTOTAL II.	2.69	33.96%	NA	NA	$208,156.07	$11,200.00
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	0.89	11.24%	21	0.04	$68,869.48	$14,900.00
B. Desk Reviews in Regional Office	0.54	8.82%	9	0.06	$41,785.98	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.38	4.55%	10	0.04	$27,857.32	$3,100.00
B. Desk Reviews in Regional Office	0.39	4.92%	22	0.02	$30,178.76	$0.00
SUBTOTAL III.	2.18	27.53%	NA	NA	$168,891.54	$18,000.00
GRAND TOTAL ALL AREAS	7.92	100.00%	NA	NA	$612,861.00	$30,400.00

SUMMARY FOR RO (Enter I - X):	V	REPORTING QUARTER OF FY 2005 (Enter 1-4):				4
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO V =	Percent of Total FTEs RO V	Number Of Activities Completed RO V	FTE Per Activity RO V	Personnel Cost Per Activity* TOTAL for RO V	Travel Cost Per Activity TOTAL for RO V
	10.00				$854,000.00	$22,248.65
I. FRONT-END FINANCIAL MANAGEMENT					(Qtr 4 Only)	
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.52	5.19%	46	0.01	$44,315.67	$22.05
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.34	3.39%	5	0.07	$28,954.90	$620.55
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.20	1.97%	5	0.04	$16,826.24	$257.25
4. Financial Administrative Policy Technical Assistance	0.22	2.15%	137	0.00	$18,369.08	$607.95
SUBTOTAL I.A.	1.27	12.70%	192	NA	$108,465.89	$1,507.80
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.79	7.89%	37	0.02	$67,402.24	$857.36
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.39	3.85%	30	0.01	$32,910.24	$268.60
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.26	2.61%	9	0.03	$22,287.32	$1,231.77
8. Financial Program Policy Technical Assistance	0.42	4.17%	125	0.00	$35,622.32	$701.40
SUBTOTAL I.B.	1.85	18.53%	201	NA	$158,222.13	$3,059.32
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	1.51	15.05%	15	0.10	$128,539.89	$4,445.46
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.20	1.98%	6	0.03	$16,871.71	$23.10
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.72	7.19%	31	0.02	$61,405.16	$60.90
12. Deferrals and Disallowances	0.69	6.87%	31	0.03	$75,717.19	$1,207.50
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.72	7.22%	133	0.01	$61,648.22	$2,146.25
SUBTOTAL II.	4.03	40.30%	216	NA	$344,182.16	$7,883.21
III. QUARTERLY REVIEWS						
14 Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	1.90	18.98%	48	0.04	$162,077.52	$7,948.22
B. Desk Reviews in Regional Office	0.44	4.40%	0	na	$37,610.05	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.38	3.83%	48	0.01	$32,701.95	$1,850.10
B. Desk Reviews in Regional Office	0.13	1.26%	0	na	$10,740.29	$0.00
SUBTOTAL III.	2.85	28.47%	96	NA	$243,129.82	$9,798.32
GRAND TOTAL ALL AREAS	10.00	100.00%	705	NA	$854,000.00	$22,248.65

* Report Total Personnel Costs in Cell F7 for Entire Fiscal Year Only in Quarter 4 RO FMWR

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005						
REGION (ENTER I - X):	VI					SUMMARY FOR RO VI
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO VI =	Percent of Total FTEs RO VI	Number Of Activities Completed RO VI	FTE Per Activity RO VI	Personnel Cost Per Activity TOTAL for RO VI	Travel Cost Per Activity TOTAL for RO VI
	8.00				$481,645.00	$33,219.00
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.50	6.33%	15	0.03	$40,137.06	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.25	4.17%	5	0.05	$20,068.54	$0.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.00	0.00%	0	na	na	$0.00
4. Financial Administrative Policy Technical Assistance	0.40	8.67%	100	0.00	$32,109.67	$0.00
SUBTOTAL I.A.	1.15	19.17%	NA	NA	$92,315.29	$0.00
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.20	3.33%	50	0.00	$18,054.63	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.20	3.33%	3	0.07	$16,054.63	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.10	1.67%	20	0.01	$8,027.42	$0.00
8. Financial Program Policy Technical Assistance	0.50	8.33%	100	0.01	$40,137.08	$0.00
SUBTOTAL I.B.	1.00	16.67%	NA	NA	$60,274.17	$0.00
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	1.00	16.67%	5	0.20	$80,274.17	$15,000.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.20	3.33%	10	0.02	$16,054.83	$0.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.25	4.17%	15	0.02	$20,068.54	$0.00
12. Deferrals and Disallowances	0.45	7.50%	10	0.05	$36,123.38	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.20	3.33%	75	0.00	$16,054.83	$0.00
SUBTOTAL II.	2.10	35.00%	NA	NA	$168,575.75	$15,000.00
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	0.95	15.83%	21	0.05	$76,260.46	$9,110.00
B. Desk Reviews In Regional Office	0.45	7.50%	3	0.15	$36,123.38	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.25	4.17%	21	0.01	$20,068.54	$9,109.00
B. Desk Reviews In Regional Office	0.10	1.67%	3	0.03	$8,027.42	$0.00
SUBTOTAL III.	1.75	29.17%	NA	NA	$140,479.79	$18,219.00
GRAND TOTAL ALL AREAS	6.00	100.00%	NA	NA	$481,645.00	$33,219.00

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005

REGION (ENTER I - X):	VII					SUMMARY FOR RO VII
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO VII =	Percent of Total FTEs RO VII	Number Of Activities Completed RO VII	FTE Per Activity RO VII	Personnel Cost Per Activity TOTAL for RO VII	Travel Cost Per Activity TOTAL for RO VII
	5.00				$366,447.00	$18,199.00
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.10	2.00%	0	na	$7,328.94	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.05	1.00%	0	na	$3,664.47	$0.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.00	0.00%	0	na	na	$0.00
4. Financial Administrative Policy Technical Assistance	0.10	2.00%	0	na	$7,328.94	$0.00
SUBTOTAL I.A.	0.25	5.00%	NA	NA	$18,322.35	$0.00
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-institutional State Plan Amendments (e.g., TCM, schools)	0.00	0.00%	0	na	na	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.00	0.00%	0	na	na	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.00	0.00%	0	na	na	$0.00
8. Financial Program Policy Technical Assistance	0.10	2.00%	0	na	$7,328.94	$0.00
SUBTOTAL I.B.	0.10	2.00%	NA	NA	$7,328.94	$0.00
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	1.70	34.00%	0	na	$124,591.98	$3,857.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.00	0.00%	0	na	na	$0.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.50	10.00%	0	na	$36,644.70	$0.00
12. Deferrals and Disallowances	0.40	8.00%	0	na	$29,315.76	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.10	2.00%	0	na	$7,328.94	$0.00
SUBTOTAL II.	2.70	54.00%	NA	NA	$197,881.38	$3,857.00
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	1.70	34.00%	0	na	$124,591.98	$12,342.00
B. Desk Reviews in Regional Office	0.00	0.00%	0	na	na	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.00	0.00%	0	na	na	$0.00
B. Desk Reviews in Regional Office	0.25	5.00%	0	na	$18,322.35	$0.00
SUBTOTAL III.	1.95	39.00%	NA	NA	$142,914.33	$12,342.00
GRAND TOTAL ALL AREAS	5.00	100.00%	NA	NA	$366,447.00	$18,199.00

SUMMARY FOR RO (Enter I - X):	VIII	RTERLY RO FINANCIAL MANAGEMENT WORKPLAN REPORT (RO FMWR) FOR FY:				4
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO VIII =	Percent of Total FTEs RO VIII	Number Of Activities Completed RO VIII	FTE Per Activity RO VIII	Personnel Cost Per Activity* TOTAL for RO VIII	Travel Cost Per Activity TOTAL for RO VIII
	2.75				$251,958.00	$11,900.00
I. FRONT-END FINANCIAL MANAGEMENT					(Qtr 4 Only)	
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.14	5.09%	7	0.02	$12,826.95	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.04	1.45%	1	0.04	$3,664.84	$0.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.00	0.00%	0	NA	NA	$0.00
4. Financial Administrative Policy Technical Assistance	0.06	2.18%	60	0.00	$5,497.27	$0.00
SUBTOTAL I.A.	0.24	8.73%	NA	NA	$21,989.06	$0.00
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.00	0.00%	0	NA	NA	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.04	1.45%	20	0.00	$3,664.84	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.10	3.64%	11	0.01	$9,162.11	$0.00
8. Financial Program Policy Technical Assistance	0.31	11.27%	220	0.00	$28,402.54	$0.00
SUBTOTAL I.B.	0.45	16.36%	NA	NA	$41,229.49	$0.00
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	0.73	26.55%	3	0.24	$66,883.40	$6,000.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.09	3.27%	0	NA	$8,245.90	$0.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.08	2.91%	6	0.01	$7,329.69	$0.00
12. Deferrals and Disallowances	0.18	6.55%	9	0.02	$16,491.80	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.10	3.64%	71	0.00	$9,162.11	$0.00
SUBTOTAL II.	1.18	42.91%	NA	NA	$108,112.89	$6,000.00
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	0.16	5.82%	7	0.02	$14,659.37	$5,900.00
B. Desk Reviews in Regional Office	0.65	23.64%	41	0.02	$59,553.71	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.00	0.00%	0	NA	NA	$0.00
B. Desk Reviews in Regional Office	0.07	2.55%	48	0.00	$6,413.48	$0.00
SUBTOTAL III.	0.88	32.00%	NA	NA	$80,626.56	$5,900.00
GRAND TOTAL ALL AREAS	2.75	100.00%	NA	NA	$251,958.00	$11,900.00

* Report Total Personnel Costs in Cell F7 for Entire Fiscal Year Only in Quarter 4 RO FMWR

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005						
Region (Enter I - X):	IX					SUMMARY FOR RO IX
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO IX =	Percent of Total FTEs RO IX	Number Of Activities Completed RO IX	FTE Per Activity RO IX	Personnel Cost Per Activity TOTAL for RO IX	Travel Cost Per Activity TOTAL for RO IX
	6.00				$540,000.00	$21,100.00
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.18	3.00%	12	0.02	$16,200.00	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.16	2.87%	12	0.01	$14,400.00	$0.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.06	1.00%	8	0.01	$5,400.00	$0.00
4. Financial Administrative Policy Technical Assistance	0.52	8.67%	238	0.00	$46,800.00	$0.00
SUBTOTAL I.A.	0.92	15.33%	NA	NA	$82,800.00	$0.00
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.23	3.83%	17	0.01	$20,700.00	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.20	3.33%	15	0.01	$18,000.00	$0.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.34	5.67%	15	0.02	$30,600.00	$0.00
8. Financial Program Policy Technical Assistance	0.64	10.67%	270	0.00	$57,600.00	$0.00
SUBTOTAL I.B.	1.41	23.50%	NA	NA	$126,900.00	$0.00
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	0.47	7.83%	6	0.08	$42,300.00	$9,300.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.26	4.33%	5	0.05	$23,400.00	$0.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.22	3.67%	31	0.01	$19,800.00	$0.00
12. Deferrals and Disallowances	0.15	2.50%	25	0.01	$13,500.00	$0.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.25	4.17%	57	0.00	$22,500.00	$0.00
SUBTOTAL II.	1.35	22.50%	NA	NA	$121,500.00	$9,300.00
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	0.77	12.83%	14	0.06	$69,300.00	$11,800.00
B. Desk Reviews in Regional Office	0.98	16.33%	44	0.02	$88,200.00	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.10	1.67%	4	0.03	$9,000.00	$0.00
B. Desk Reviews in Regional Office	0.47	7.83%	35	0.01	$42,300.00	$0.00
SUBTOTAL III.	2.32	38.87%	NA	NA	$208,800.00	$11,800.00
GRAND TOTAL ALL AREAS	6.00	100.00%	NA	NA	$540,000.00	$21,100.00

REGIONAL OFFICE MEDICAID & SCHIP FINANCIAL MANAGEMENT WORKPLAN--FOR FISCAL YEAR 2005

REGION (ENTER I - X):	X					SUMMARY FOR RO X
A	B	C	D	E	F	G
FINANCIAL MANAGEMENT ACTIVITIES FY2005FMPWP.xls	TOTAL FTEs For RO X =	Percent of Total FTEs RO X	Number Of Activities Completed RO X	FTE Per Activity RO X	Personnel Cost Per Activity TOTAL for RO X	Travel Cost Per Activity TOTAL for RO X
	5.00				$396,238.00	$41,000.00
I. FRONT-END FINANCIAL MANAGEMENT						
A. ADMINISTRATIVE PROGRAM DEVELOPMENT						
1. Cost Allocation Plans (e.g., multi-opdiv, State match)	0.15	3.00%	4	0.04	$11,947.14	$0.00
2. Administrative Claiming Plans (e.g., schools, mental health, administrative case management)	0.10	2.00%	4	0.03	$7,964.76	$1,000.00
3. Prior Approval of Procurements, Contracts, or APDs Required By Regulation	0.30	6.00%	65	0.00	$23,894.28	$6,000.00
4. Financial Administrative Policy Technical Assistance	0.15	3.00%	65	0.00	$11,947.14	$0.00
SUBTOTAL I.A.	0.70	14.00%	NA	NA	$55,753.32	$7,000.00
B. SERVICES PROGRAM DEVELOPMENT						
5. Medicaid & SCHIP Program Non-Institutional State Plan Amendments (e.g., TCM, schools)	0.25	5.00%	55	0.00	$19,911.90	$0.00
6. Institutional State Plan Amendments (e.g., UPL, DSH, IHS)	0.50	10.00%	12	0.04	$39,823.80	$2,000.00
7. Waiver Submissions (e.g., 1115, 1915(b) & (c), Managed Care)	0.10	2.00%	30	0.00	$7,964.76	$3,000.00
8. Financial Program Policy Technical Assistance	0.15	3.00%	60	0.00	$11,947.14	$0.00
SUBTOTAL I.B.	1.00	20.00%	NA	NA	$79,647.60	$5,000.00
II. ONGOING FM OVERSIGHT/ENFORCEMENT						
9. Focused Financial Management Reviews (e.g., DSH, Schools, UPL)	0.50	10.00%	5	0.10	$39,823.80	$6,000.00
10. Financial Portion Of Program Reviews/Workgroups (e.g., Waivers, Budget Neutrality)	0.10	2.00%	6	0.02	$7,964.76	$0.00
11. Audit Liaison & Resolution (e.g., GAO, OIG, Single Audits)	0.50	10.00%	12	0.04	$39,823.80	$4,500.00
12. Deferrals and Disallowances	0.40	8.00%	8	0.05	$31,859.04	$1,000.00
13. Financial Data & Information Gathering (e.g., UPL, schools)	0.50	10.00%	80	0.01	$39,823.80	$0.00
SUBTOTAL II.	2.00	40.00%	NA	NA	$159,295.20	$13,500.00
III. QUARTERLY REVIEWS						
14. Expenditure Reviews (HCFA-64 & HCFA-21)						
A. On-Site Reviews	1.00	20.00%	16	0.08	$79,647.60	$10,600.00
B. Desk Reviews In Regional Office	0.00	0.00%	0	na	na	$0.00
15. Budget Reviews (HCFA 37 & HCFA 21B)						
A. On-Site Reviews	0.30	6.00%	16	0.02	$23,894.28	$4,900.00
B. Desk Reviews In Regional Office	0.00	0.00%	0	na	na	$0.00
SUBTOTAL III.	1.30	26.00%	NA	NA	$103,541.86	$15,500.00
GRAND TOTAL ALL AREAS	5.00	100.00%	NA	NA	$398,238.00	$41,000.00

Question 11:

I also believe good government means having access to comprehensive and reliable data upon which to base sound public policy decisions. The Administration has proposed to "crack down" on people transferring assets in order to qualify for Medicaid. While none of us believe rich people should be taking advantage of the Medicaid program, I have not seen any data from CMS that explains the extent to which asset transfers are actually occurring. In effect, the Administration is asking Congress to consider a policy with no sound data on the extent of the problem in the states. Mr. Smith, can you tell the members of this Committee if and when the Administration plans to provide Congress with state-by-state data on the extent to which asset transfers are occurring?

Answer:

The GAO has issued a report, "Medicaid: Transfers of Assets by Elderly Individuals to Obtain Long-Term Care Coverage" (GAO-05-968) related to the extent to which transfers of assets are made by elderly individuals to obtain Medicaid long-term care coverage. In addition, CMS released a study in January 2005, "Analysis of the Use of Annuities to Shelter Assets in State Medicaid Programs" focusing on the use of annuities as a means to circumvent transfer of assets rules. In both of these studies the researchers observed that states generally did not have state-level data and did not track or analyze data on asset transfers or annuity use in the state. Thus, efforts to determine the extent to which asset transfers are occurring rely on sampling and estimates. States have noted that transfers of assets not reported by Medicaid applicants or by third parties are difficult to identify.

Question 12:

Could you also provide the Members of this Committee with a state-by-state analysis of estate recovery laws in each state? I am particularly interested in the asset exemptions that each state allows for individuals going into Medicaid long-term care facilities.

Answer:

The recent report "Medicaid Estate Recovery: A 2004 Survey of State Programs and Practices" published in June 2005 by the AARP Public Policy Institute and available on the AARP website at: http://www.aarp.org/research/assistance/medicaid/2005_06_recovery.html surveyed each state and reported and analyzed their laws, policies and practices with respect to estate recovery. Conduct of this study was aided by the Technical Expert Panel, organized by the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, AARP, and the ABA Commission on Law and Aging.

Specific information about each state's asset exemptions may be obtained in AARP's report, discussed above. With respect to general Medicaid eligibility rules, the assets that states can allow an individual to retain and still qualify for Medicaid long-term care are essentially determined according to the rules of the Supplemental Security Income program. The major resource exclusions are: $2,000 in resources for a single individual; a house, co-op or condo in which the individual or spouse lives, or if temporarily absent, to which he or she intends to return; a car; ordinary household goods; value of any burial space and a burial fund; and life insurance policies with a face value of less than $1,500. In addition, states are required to follow the provisions of Section 1924 of the Social Security Act ("the Act"), including the resource provisions, with respect to protecting assets for the community spouses of institutionalized individuals. States may adopt more liberal rules for exempting assets than those used by the SSI program for some Medicaid eligibility groups under Section 1902(r)(2) of the Social Security Act, but may not target such exemptions to recipients of care in long-term care facilities.

Question 13:

In the fall of 2004, the Centers for Medicare and Medicaid Services (CMS) published the Federal Medical Assistance Percentage (FMAP) for fiscal year 2006 based on per capita income (PCI) data from 2001, 2002, and 2003. Federal law dictates that the FMAP is determined based on the "three most recent calendar years for which satisfactory data are available from the Department of Commerce." Thus, for FY 2006, the PCI data used are from the years 2001, 2002, and 2003. The federal intent of a three-year rolling average is to limit the fluctuations that states might experience since only one-third of the formula is changed on a yearly basis. However, the U.S. Department of Commerce's Bureau of Economic Analysis (BEA) performed a comprehensive revision of its calculation of PCI in 2003, as it does every four to five years, and provided revised data for previous years as well. As a result, CMS changed the 2001 and 2002 PCI data for states in the calculation of FMAP. Consequently, all three years of the PCI data were being changed rather than just one-third. The result is rather dramatic fluctuations to state FMAP calculations. Twenty-nine states, including my home state of West Virginia (which will lose $36 million), are expected to experience FMAP reductions in 2006. Not since 1998 have the fluctuations been this dramatic. Can you explain the reason for this dramatic fluctuation?

Answer:

The calculation for the 2006 FMAPs was performed, as mandated by Section 1101(a)(8)(B)), using "per capita income of each State and of the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce." For the 2006 FMAP calculations, the most recent per capita income data available from the Department of Commerce's Bureau of Economic Analysis (BEA) was the 2001 to 2003 per capita income data released on September 28, 2004.

The FMAPs are calculated in accordance with the statutorily defined formula using the summer/fall BEA data release and then published in the Federal Register as required. The Secretary is to determine the percentages, using formulas explicitly defined in sections 1905(b) and 1101(a)(8)(B), and therefore the Department has no discretion in the formula or data used to calculate the FMAPs.

There are two principle causes for the larger-than-usual number of states with declining FMAPs. First, calendar year 2000 data, which had been used in the 2003, 2004 and 2005 FMAP calculations, is no longer part of the three year average of state per capita income used to determine the 2006 FMAPs. In 2000, some large, wealthy states had strong economies that subsequently weakened. The absence of the 2000 data in the FY 2006 FMAP calculation makes other states look relatively wealthier, resulting in a reduced FMAP from the prior years.[1] In addition, BEA periodically rebenchmarks their methodology for calculating per capita income, and such rebenchmaking can cause larger-than-normal shifts in state per capita figures from one year to the next. The 2006 FMAPs reflect a recent rebenchmarking by BEA.

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[1] Miller, Vic. *FFIS Issue Brief 04-41: FY 2006 FMAPs*, September 28, 2004.

Question 14:

Has CMS ever revised all three years of the PCI data based on a Bureau of Economic Analysis revision? If so, when? If not, why did CMS do so this time?

Answer:

Many think CMS calculates the FMAP rates but CMS has never calculated the FMAPs. The FMAP rates are calculated by the Office of the Assistant Secretary for Planning and Evaluation (ASPE). Prior to ASPE it was the Administration for Children and Families (ACF), which makes historical sense because FMAP rates started with welfare (AFDC) long before Medicaid existed.

ASPE uses the 3 most recent years of data that BEA publishes, and has consistently used what BEA considers to be the most accurate 3-year average of per capita income, since that average should represent the most accurate measure of a state's economic strength. ASPE does not have the discretion to choose a different set of data from what BEA publishes.

Question 15:

As I read the testimony on state financing in preparation for panel 3 tomorrow, I kept wondering why we are having a hearing to discuss state financing when clearly there are federal financing issues that CMS has refused to address for over a decade. In February of this year, the GAO released a report entitled "Medicaid Drug Rebate Program: Inadequate Oversight Raises Concerns About Rebates Paid to States" in which it found that:

- **Current rebate program oversight does not ensure that manufacturer-reported prices or price determination methods are consistent with program criteria specified in the rebate statute, rebate agreement, and [CMS] program memoranda.**
- **In administering the program, CMS conducts only limited checks for reporting errors in manufacturer-reported drug prices; and**
- **CMS only reviews the price determination methods when manufacturers request recalculation of prior rebates.**

Yet, this isn't the first time a report detailing CMS' lack of guidance and oversight with the Medicaid rebates has been noted. In fact, the HHS Inspector General has produced several reports, dating back to 1992, which point out problems with CMS' management of the program.

Why hasn't CMS issued clear guidance in this area and uniformly defined Medicaid best price?

Answer:

CMS has issued considerable guidance to drug manufacturers and states since the beginning of the drug rebate program. The Medicaid Drug Rebate Agreement defines key terms used in the program such as Average Manufacturers Price (AMP) and Best Price (BP.) In a final regulation published last year CMS set requirements for drug manufacturers on record retention (10 years) and limit the time period during which manufacturers may revise their reported AMP and BP (3 years). We also regularly publish releases to manufacturers (69 to date) and Medicaid Directors (137 to date) in which we clarify policy as needed.

Question 16:

What is CMS doing to address the fraudulent practice by brand name drug companies of disregarding the price of so-called "authorized generics" when reporting Medicaid best price as required for Medicaid rebates?

Answer:

CMS's policy is and has been that authorized generics should be treated as innovator multiple source drugs for the purposes of the Medicaid best price statute. Section 1927(k)(7)(A)(ii) of the Social Security Act defines innovator multiple source drugs as multiple source drugs that were originally marketed under brand manufacturer's original new drug application (NDA) approved by the FDA. The drug rebate agreement signed by drug manufacturers provides that "a Covered Outpatient Drug marketed by a cross-licensed producer or distributor under the approved NDA shall be included as an innovator multiple source drug . . ." Thus, if the authorized generic is a multiple source drug being marketed pursuant to the brand manufacturer's NDA, the authorized generic should be categorized or classified as an innovator multiple source drug. As a result, the drug rebate paid by the manufacturer of the authorized generic drug should be the greater of 15.1 percent of the average manufacturer's price (AMP) or the difference between the AMP and best price (BP). CMS confirmed this policy most recently in response to a question that arose at Secretary Leavitt's confirmation hearing.

Congressional
Research
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Medicaid Asset Transfers and Estate Planning
Testimony Before the Senate Committee on Finance

June 29, 2005

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Congressional Research Service *Washington, D.C. 20540-7000*
CRS prepared this memorandum to enable distribution to more than one congressional client.

Good morning Mr. Grassley, Mr. Baucus, and members of the committee. My name is Julie Stone-Axelrad and I am a health policy analyst at the Congressional Research Service. In an attempt to help set the stage for your policy discussions about Medicaid asset transfers and estate planning, my testimony addresses several topics. First, I review Medicaid's eligibility rules for people needing long-term care. Next, I summarize Medicaid rules regarding asset transfers and estate recovery. At the request of this committee, I then provide examples of how people may divest assets. I also briefly discuss state efforts to limit such transfers. I conclude by offering information about how common such activities may be and their potential cost.

Introduction

Medicaid is a means-tested program and covers about 54 million people across the nation, including children and families, persons with disabilities, pregnant women, and the elderly. Although the program is targeted at low-income individuals, not all of the poor are eligible, and not all of those covered are poor. To qualify, applicants' income and assets must be within specified limits. There are three general ways in which applicants meet these requirements: (1) they have income and assets equal to or below state-specified thresholds; (2) they deplete their income and assets on the cost of their care, thus, "spending down"; or (3) they divest their assets to qualify for Medicaid sooner then they otherwise would.

In calendar year 2003, combined federal and state spending on Medicaid was $250 billion. Of this amount, spending on long-term care services totaled $86.3 billion, or about one third of total program spending.[1] Some policymakers are concerned that the aging of the population will lead to increased demand for long-term care services, further shifting scarce federal and state dollars toward the Medicaid program and away from spending for other purposes. States are also concerned about the high cost of long-term care services.

Medicaid estate planning is a means by which elderly people divest their income and assets to qualify for Medicaid's coverage sooner than they would if they first had to spend their income and assets on the cost of their care. It is also a means by which persons may protect their assets from estate recovery. Motivation for this activity is, in part, a result of the high costs of long-term care services (e.g., a MetLife survey of a select group of nursing homes across the country found that for these facilities the average daily rate of a semi private room was $169 daily, or $61,685 per year in 2004) and the fear that these costs could quickly deplete savings.[2] For the purposes of Medicaid estate planning, this issue applies primarily to a subset of the Medicaid population, specifically a group of those persons age 65 and over who need long-term care services (such as nursing home or home and community-based services) and whose income is greater than $579 per month (or 73% of the federal poverty level).

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[1] CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS). This analysis also includes unpublished data from CMS, National Health Statistics Group on Medicaid and Medicare expenditures for hospital-based nursing home and home health providers, and data for the Medicaid 1915(c) home and community-based waivers.

[2] MetLife's survey of 790 home health agencies, also found that the average per hour private pay rate of a home health aide was $18. For a person needing 40 hours of care per week, for example, that would equal $37,440 per year. MetLife Market Survey of Nursing Home and Home Care Costs, Metlife Mature Market Institute, Westport, CT, Sept. 2004.

Concern about these practices has resurfaced in recent years as part of the larger policy debate about the financial strains on federal and state budgets in general, and the increasing costs of Medicaid's long-term care coverage in particular. It is also part of a growing interest by policymakers in assessing the extent to which Medicaid plays a role as a safety net program for persons who are poor as well as the extent to which it plays a defacto role as a long-term care insurance program.

Despite Congress' efforts to discourage asset transfers through the establishment of new asset transfer rules in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), current law has not been able to preclude all available means of protecting assets. A variety of methods may still be used to protect assets and enable persons to obtain Medicaid coverage while using personal resources for other purposes, such as for making gifts to children or third parties, maintaining a certain standard of living, making improvements to one's home, or ensuring larger inheritances for heirs, than would otherwise be available.

Some of the methods listed in this testimony appear to be unintended consequences of Medicaid laws that were designed to protect persons who are poor or have high medical expenses and in need of Medicaid's assistance. However, that not all methods of transferring assets are necessarily in conflict with the spirit of Medicaid law. Whereas some persons refer to these provisions in the statute as "loopholes," others suggest that they reflect a lack of consensus among the law's drafters about the extent to which asset transfers should be statutorily prohibited. They also likely reflect the difficulty in writing legislative language to discourage *all* methods for transferring assets while not simultaneously restricting access to Medicaid's safety net services.

Critics of Medicaid estate planning often explain that asset sheltering places a financial strain on the Medicaid program and directs scarce resources away from people who are most needy to pay for care for people who are less needy. Some critics also object to this practice on moral grounds, asserting that people should assume financial responsibility for their own long-term care services before relying on tax dollars to pay for care they could otherwise afford.

Others indicate that people who engage in Medicaid estate planning do so because of the absence of a nationwide social insurance program covering long-term care services for the elderly. In addition, they explain that Medicaid's generally low allowable asset limit (often $2,000 excluding a home and certain other assets listed below) often leave persons with long-term care needs without the resources they need to remain at home and requires them to become virtually destitute before they can receive assistance in paying for their care.

Any changes to Medicaid law designed to discourage asset transfers may impact other groups of eligibles as well, particularly those who may have transferred assets without any intention of ever needing Medicaid's assistance. Consideration of these implications may be a critical component of the evaluation of different policy options.

Medicaid Eligibility for the Aged (Age 65 and Over)

To qualify for Medicaid, an individual must meet both categorical *and* financial eligibility requirements. Categorical eligibility requirements relate to the age or characteristics of an individual. Aged persons (age 65 and over), certain persons with disabilities, children and their parents, and pregnant women are among the categories of individuals who may qualify. Financial requirements limit the amounts of income and assets[3] individuals may have to become eligible for Medicaid (often referred to as standards or thresholds) and provide guidelines for how these amounts are calculated (counting methodologies).

The specific income and asset limitations that apply to each eligibility group are set through a combination of federal parameters and state definitions. Consequently, those standards vary considerably among states, and different standards apply to different population groups within a state.

Major Income Pathways

Below is a description of the eligibility criteria for the major income groups. The groups include people who either are receiving cash assistance from the Supplemental Security Income program or have income that does not exceed 100% of the federal poverty level (FPL). Medicaid law also allows states to cover people with higher income if they require the level of care offered in an institution, such as a nursing home, or if they have medical expenses that deplete their income to specified levels.[4] Note that low-income elderly persons without long-term care needs and younger persons with disabilities also qualify for Medicaid through many of these pathways.

Supplemental Security Income (SSI). In general, many Medicaid enrollees who are aged qualify because they meet the financial eligibility requirements of the Supplemental Security Income (SSI) program, which provides cash benefits to disabled, blind, or aged individuals who have income that does not exceed $579 per month in 2005, or about 73% of the federal poverty level (FPL),[5] for an individual, and $869 for a couple. Although most states allow persons who meet SSI's eligibility criteria to qualify for Medicaid, eleven apply more restrictive criteria to either the income, assets or disability tests.[6] These states are often referred to as 209(b) states. As of 2003, these states were Connecticut, Hawaii, Illinois,

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[3] For purposes of Medicaid eligibility, assets are often referred to as resources and the terms may be used interchangeably. Resources include cash and other liquid assets or personal property that individuals (or their spouses) own and could convert to cash. As described later in this testimony, not all resources are counted for purposes of determining Medicaid eligibility.

[4] For more information about Medicaid's eligibility criteria for this population, see CRS Report RL31413, *Medicaid: Eligibility for the Aged and Disabled*, by Julie Stone-Axelrad.

[5] In 2005, 100% of the 2005 federal poverty level is $9,570 per year, or $758 per month for an individual and $12,830 for a couple, or $1,069 per month, in the 48 contiguous United States and the District of Columbia. In Alaska, this level is $11,950 per year, or $996 per month, and in Hawaii, it is $11,010, or $918 per month for individuals, see [http://aspe.hhs.gov/poverty/05poverty.shtml].

[6] Each of these states has at least one eligibility standard that is more restrictive than current SSI standards, and some also have standards that are more liberal.

Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia.[7]

100% of FPL. States also have an option to cover persons whose income exceeds SSI levels but is *no greater than* 100% of FPL. As of 2003, 20 states and the District of Columbia used this option.[8]

Special Income Rule. Alternatively, states may extend Medicaid to certain individuals with incomes too high to qualify for SSI or the 100% option (if available), and who need the level of care that would be provided in a nursing facility or other institution.[9] Under the special income rule, also referred to as "the 300% rule," such persons may have income that does not exceed a specified level established by the state, but *no greater than* 300% of the maximum SSI payment applicable to a person living at home. For 2005, this limit is $1,737 per month (three times the monthly SSI payment of $579), or about 218% FPL. A number of states also allow persons to place income in excess of the special income level in a trust, called a Miller Trust, and receive Medicaid coverage for their care.[10] Following the individual's death, the state becomes the beneficiary of amounts in this trust.

Spend-Down Groups. Federal law also gives states the option of allowing aged persons with high medical expenses to qualify for Medicaid through so-called "spend-down" groups. Under these groups, people qualify only if their medical expenses (on such things as nursing home care, prescription drugs, etc.) deplete, or spend down, their income and assets to specified Medicaid thresholds.[11] For example, if an individual has monthly income of $1,000 and the state's income standard is $480, then the applicant would be required to incur $520 in out-of-pocket medical expenses before he or she would be eligible for Medicaid. States use a specific time period for calculating a person's medical expenses, generally ranging from one month to six months.[12]

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[7] A 2003 eligibility survey conducted by the American Public Human Services Association in collaboration with the Congressional Research Service.

[8] Source: A 2003 eligibility survey conducted by the American Public Human Services Association in collaboration with Congressional Research Service. The District of Columbia allowed people to qualify up to 100% of FPL. Other states using this option included: Arkansas (up to 80%), California (100%), Florida (88%), Georgia (100%), Hawaii (100%), Illinois (100%), Maine (100%), Massachusetts (100%), Michigan (100%), Minnesota (95%), Mississippi (100%), Nebraska (100%), New Jersey (100%), North Carolina (100%), Oklahoma (100%), Pennsylvania (100%), Rhode Island (100%), South Carolina (100%), Utah (100%), and Virginia (80%).

[9] Care must be needed for no fewer than 30 consecutive days.

[10] Since 1993 (OBRA 93), states that use only the special income rule for institutional eligibility, and do not use the medically needy option, must allow for income-only trusts.

[11] States may use spend down groups to extend Medicaid coverage to persons who are members of one of the broad categories of Medicaid covered groups (i.e., are aged, have a disability, or are in families with children), but do not meet the applicable income requirements and, in some instances, resources requirements for other eligibility pathways.

[12] The calculation becomes the basis for determining the amount of a person's spend-down requirement. Generally a shorter time period is more beneficial to the applicant. For example, if the state has a one month spend-down calculation period, the individual would be required to incur $520 in medical expenses in a month, after which services would be covered by Medicaid. On the other hand, if the state had a six month calculation period, the individual would have to incur a projected amount of $3,120 ($520 times six) in medical expenses before Medicaid would begin coverage. The length of the spend-down period does not significantly affect total out-of-pocket expenditures for

(continued...)

The most common spend down group is referred to as "medically needy." Under this option, states may set their medically needy monthly income limits for a family of a given size at any level up to 133 % of the maximum payment for a similar family under the state's AFDC program in place on July 16, 1996.[13] The monthly income limits are often lower than the income standard for elderly SSI recipients (i.e., less than $579 monthly in 2005). Once eligible for Medicaid, beneficiaries who qualify under these rules must continue to apply their income above medically needy thresholds toward the cost of their care. As a result, elderly recipients living in the community who must spend down to qualify for Medicaid generally are allowed to retain less money for their living expenses than Medicaid beneficiaries who qualify through SSI. In 2003, 33 states had medically needy programs for persons age 65 and older.[14]

The second spend down group is available in all 209(b) states. Federal law requires those states that apply more restrictive criteria to the SSI population (see above) to allow these individuals to deduct medical expenses from their income when determining eligibility for Medicaid.

Post-Eligibility Treatment of Income. Once eligible for Medicaid, persons are required to apply their income toward the cost of their care. The amounts they may retain vary by setting. For example, Medicaid beneficiaries in a nursing home may retain a personal needs allowance (these amounts ranged from $30 to $70 per month in 2003). Persons receiving services in home and community-based settings may retain a maintenance needs allowance (these amounts ranged from $500 to $2,267 per month in 2003). All income amounts above these levels, including what may be available in a Miller Trust, must be applied toward the cost of their care.

General Rules Regarding Assets

Under the Medicaid program, states also set asset standards, within federal parameters, that applicants must meet to qualify for coverage. These standards specify the amount of countable assets a person may have to qualify. In general, countable assets cannot exceed $2,000 for an individual. However, not all assets are counted for eligibility purposes. The standards states set also include criteria for defining non-countable, or exempt, assets. States generally follow SSI rules for computing both countable and non-countable assets.

Under Medicaid and SSI rules, excluded assets include an individual's primary place of residence, one automobile, household goods and personal effects,[15] property essential to

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[12] (...continued)
persons with predictable and recurring medical expenses, such as persons with chronic illnesses or disabling conditions. However, individuals faced with acute nonrecurring problems generally benefit more from a shorter calculation period.

[13] For families of one, the statute gives certain states some flexibility to set these limits to amounts that are reasonably related to the AFDC payment amounts for two or more persons.

[14] These include Alaska, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

[15] Under former SSI rules, there were restrictions placed on the value of the automobile and household goods and personal effects that could be excluded from countable assets. As of March
(continued...)

income-producing activity, up to $1,500 in burial funds, life insurance policies whose total face value is not greater than $1,500, and miscellaneous other items. **Appendix 1** provides a more detailed description of SSI's program rules regarding countable and non-countable assets. Under certain conditions (discussed later in this testimony), these non-countable assets may be considered part of a beneficiary's estate and may be available for recovery by the state Medicaid programs after the beneficiary's death.

Additional State Flexibility

The criteria described above provide a *general* description of the income and asset criteria for Medicaid. These criteria, however, vary significantly by state. Under Section 1902(r)(2) of the Social Security Act, states have the authority to use more liberal methods for computing income and assets than are specified in the Social Security Act's eligibility definition for a particular group. States can also use Section 1902(r)(2) to ignore or disregard certain types or amounts of income or assets, thereby extending Medicaid to individuals with income or assets that are above the levels that would otherwise apply to a particular eligibility pathway.

Spousal Impoverishment Rules

Medicaid law also includes provisions intended to prevent impoverishment of a spouse whose husband or wife seeks Medicaid coverage for long-term care services. These provisions were added to Medicaid law by the Medicare Catastrophic Coverage Act (MCCA) of 1988 to address the situation that would otherwise leave the spouse not receiving Medicaid (community spouse) with little or no income or assets when the other spouse is institutionized or, at state option, receives Medicaid's home- and community-based services. Before MCCA, states could consider all of the assets of the community spouse, as well as the spouse needing Medicaid coverage. These rules created hardships for the spouse living in the community who was forced to spend down virtually all of the couple's assets to Medicaid eligibility levels so that the other spouse could qualify for coverage. MCCA established new rules for the treatment of income and assets of married couples, allowing the community spouse to retain higher amounts of income and assets (on top of non-countable assets such as a house, car, etc.) than allowed under general Medicaid rules.

Regarding assets, federal law allows states to select the amount of assets a community spouse may be allowed to retain. Federal law specifies that this limit may not exceed $95,100 and may be no less than $19,020 in total countable assets in 2005.

For purposes of determining eligibility, all assets of the couple are combined and counted, regardless of ownership. If the community spouse's assets are less than the state maximum, then the Medicaid beneficiary must transfer his or her share of the assets to the community spouse until the community-spouse's share reaches the maximum. All other non-exempt assets must be depleted before the applicant can qualify for Medicaid.

Regarding income, federal law exempts all of the community spouse's income (e.g., pension or Social Security) from being considered available to the other spouse for purposes

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[15] (...continued)
9, 2005, one automobile and all household goods and personal effects are excluded, regardless of their value. 70 *Federal Register* 6340, no. 24, Feb. 7, 2005.

of Medicaid eligibility. For community spouses with more limited income, however, states set the maximum monthly income level that community spouses may retain. Federal law specifies that this limit may be no greater than $2,377.50 per month, and no less than $1,561.25 per month in 2005. Once the applicant is determined eligible for Medicaid, some of his or her income may be used to cover the cost of the monthly allowance of the community spouse. Specifically, the Medicaid recipient may choose to transfer an amount of his or her income equal to the difference between the limit and the community spouse's own income up to the state limit.[16]

States, however, have some flexibility in the way they apply these rules and the rules they have developed have sometimes been the subject of court challenges. With regard to determinations of income and asset allowances for community spouses, for example, some states have added additional standards regarding the way in which income and assets are applied to these allowances.[17]

Asset Transfer Rules

In an attempt to ensure that Medicaid applicants apply their assets toward the cost of their care and do not give them away to gain Medicaid eligibility sooner than they otherwise would, Congress established new asset transfer rules under Omnibus Budget Reconciliation Act of 1993 (OBRA 93). These rules include penalties for the transfer of assets for less than fair market value. Specifically, they require states to delay Medicaid eligibility for certain individuals applying for institutional or certain home- and community-based services if they have disposed of assets[18] for less than fair market value on or after a "look-back date." This date is 36 months prior to application for Medicaid for all income and assets and 60 months in the case of certain trusts treated as assets disposed of by the individual.[19] These rules apply to all persons receiving care in a nursing home, and, at state option, certain people receiving care in community-based settings.

Allowable Transfers

Under the law, not all asset transfers are subject to penalties. For example, asset transfers for fair market value, transfers to spouses of any value, and certain transfers to specified other persons, such as children with disabilities, for less than fair market value, are not subject to penalties. Specifically, a home may be transferred, without penalty, from an applicant to a: (1) spouse; (2) child under age 21; (3) child who is blind or permanently or totally disabled (as determined under Title XVI or 1614 of SSA); (4) sibling who has an equity interest in the home and who was residing in the applicant's home for at least one year immediately before the date the individual becomes institutionalized; or (5) son or daughter residing in an individual's home for at least two years immediately prior to the institutionalization of the applicant and who provided care that permitted the individual to reside at home rather than in an institution or facility.[20] These rules were established to ensure that certain family members would not lose their homes or be without shelter so that one member of the family could obtain Medicaid coverage.

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[16] Centers for Medicare and Medicaid Services, *Spousal Impoverishment*, available at [http://www.cms.hhs.gov/medicaid/eligibility/spousal.pdf]; *2005 SSI FBR, Resource Limits, 300% cap, Break-even Points, Spousal Impoverishment Standards*, available at [http://www.cms.hhs.gov/medicaid/eligibility/ssi0105.asp].

[17] For example, some states use an "income-first" method, others use an "asset-first"method. The "income-first" method was challenged in court, and upheld as a permissible interpretation of federal law by the Supreme Court in *Wisconsin Department of Health and Family Services v. Blumer*, 534 U.S. 473 (2002).

[18] For the purposes of asset transfer rules, the term assets includes all income and resources of the individual and of the individual's spouse. See Section 1917(e)(1) of the Social Security Act.

[19] In the case of a revocable trust, any payments from the trust shall be considered assets disposed of by the individual; in the case of an irrevocable trust, any portion of the trust or income from the corpus, from which no payment could under any circumstances be made to the individual, shall be considered to be assets improperly disposed by the individual. As of the date of the establishment of the trust (or, if later, the date on which payment to the individual was foreclosed).

In addition, all transfers of any value between spouses are permitted. In part, this is because all assets of the couple, regardless of ownership, are combined and counted for purposes of determining Medicaid eligibility for either one or both spouses. When both spouses apply for Medicaid, the couple's combined non-exempt assets may generally not exceed $3,000. When only one of the spouses applies to Medicaid, spousal impoverishment rules, described earlier, apply to the amount of assets that the community spouse is allowed to protect.

Additional exceptions are made for other types of transfers for less than fair market value. They include certain transfers to a third party by the spouse for the sole benefit of the individual's spouse or transfers to a disabled or blind child for the sole benefit of the disabled or blind child. These transfers may include the establishment of a trust, such as a special needs trust or a pooled trust, for a disabled or blind child.[21,22] These exceptions allow one spouse to retain a source of financial support for another spouse and for parents of disabled children to secure a source of financial support for their disabled children.[23]

Penalties for Improper Transfers

Medicaid law requires states to impose penalties on certain applicants (institutionalized individuals and certain non-institutionalized individuals at the state option) who have made improper transfers. These penalties are defined as months of ineligibility for certain Medicaid long-term care services. The number of months is determined by dividing the total cumulative uncompensated value of all assets transferred on or after the look-back date by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. For example, a transferred asset worth $60,000, divided by a $5,000 average monthly private pay rate in a nursing home, results in a 12-month period of ineligibility for Medicaid long-term care services. The period of ineligibility begins with the first month during which the assets were transferred. There is no limit to the length of the penalty period. The starting date of the penalty period has become a topic of policy debate and will be discussed again later in this testimony.

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[20] Section 1917(c)(2) of the Social Security Act.

[21] Section 1917(c)(2)(B) of the Social Security Act.

[22] Allowable transfers also include a transfer for the establishment of a Miller trust, or income-only trust, that is applied to the cost of the beneficiary's Medicaid care and for which the state is the beneficiary.

[23] Section 1917(c) of the Social Security Act.

Ineligibility for Medicaid coverage is limited to only certain long-term care services, and not all services covered under the program. The services for which the penalty applies include nursing facility care; services provided in any institution in which the level of care is equivalent to those provided by a nursing facility; Section 1915(c) home and community-based waiver services; home health services; and personal care furnished in a home or other locations.[24] States may choose to apply this ineligibility period to other state plan long-term care services. In general, states do not extend the penalty to Medicaid's acute care services.

To protect beneficiaries from facing unintended consequences as a result of asset transfer penalties, Medicaid law includes provisions that allow states to waive penalties for persons who, according to criteria established by the Secretary, can show that penalties would impose an undue hardship. The statute also allows waivers of penalties for persons who can demonstrate to the state (also according to the rules established by the Secretary) that they either: (1) intended to dispose of the assets either at fair market value, or for other valuable consideration; (2) the assets were transferred exclusively for a purpose other than to qualify for medical assistance; or (3) all assets transferred for less than fair market value were returned to the individual.[25]

Criminal Penalties for Transfers of Assets

In an attempt to limit Medicaid estate planning, Congress established provisions in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) that would have imposed criminal penalties on any person who knowingly and wilfully disposed of assets for the purpose of becoming eligible for Medicaid, if disposing of the assets resulted in a period of ineligibility. This law was often referred to as the "Granny Goes to Jail" law, and, largely as a result of public outcry, was repealed shortly after enactment by Section 4734 of the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33).

BBA 97 replaced HIPAA's "Granny Goes to Jail" provisions with criminal penalties for persons who assist others in disposing of assets to obtain Medicaid eligibility. Specifically, the law states that whoever, for a fee, knowingly and willfully counsels or assists an individual in disposing of assets (including by any transfer in trust) to qualify for Medicaid, if disposing of the assets results in the imposition of penalty, could be found to have committed a misdemeanor and, upon conviction, be subject to a fine of not more than $10,000 or imprisonment for not more than one year, or both.[26] This became known as the "Granny's Lawyer Goes to Jail" law.

Shortly after enactment, the U.S. Attorney General, Janet Reno, issued a letter to Members of Congress and U.S. Attorneys stating that, after careful scrutiny, the Justice Department found that the counseling provision in the provision "was unconstitutional under the First Amendment."[27] She also stated that as a result, the Department of Justice would not bring any criminal prosecutions under that provision. Not long after the release of these letters, a federal court in *New York State Bar Association v. Reno*, 999 F. Supp. 710 (D.

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[24] They also apply to home and community care for functionally disabled elderly individuals (under Section 1929). This is an optional coverage group which operates only in Texas.

[25] Section 1917(c)(2)(C) and (D) of the Social Security Act.

[26] Section 1128B(a)(6) of the Social Security Act.

[27] Letter to the Honorable Newt Gingrich, Speaker of the House, U.S. Congress from Janet Reno, Attorney General, Department of Justice, dated March 11, 1998.

N.Y. 1998) also found the statue to be unconstitutional. As a result of these determinations, the "Granny's Lawyer Goes to Jail" provision has never been enforced.

Medicaid Estate Recovery

As discussed above, beneficiaries are allowed to retain certain assets and still qualify for Medicaid. The Medicaid estate recovery program is intended to enable states to recoup these private assets (e.g., countable and non-countable assets held by recipients) upon a beneficiary's death to recover Medicaid's expenditures on behalf of these individuals. Specifically, Medicaid law requires states to recover, from the estate of the beneficiary, amounts paid by the program for certain long-term care and related services.[28]

General Statutory Requirements

There are two instances in which states are *required* to seek recovery of payments for Medicaid assistance:

- when an individual of any age is an inpatient in a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR) and is not reasonably expected to be discharged from the institution and return home; and
- when an individual age 55 years and older received Medicaid assistance for nursing facility services, home and community-based services and related hospital and prescription drug services.

In addition, for persons aged 55 and over, states are given the *option* of recovering the amount of funds spent on *any other* items or services covered under the state Medicaid plan.[29]

For purposes of these recovery requirements, estates are defined as all real and personal property and other assets in an estate as defined in state *probate* law. At the option of the state, recoverable assets also may include any other real and personal property and other assets in which the person has legal title or interest at the time of death, including assets conveyed to a survivor, heir, or through assignment through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.[30] Thus assets, such as living trusts, life insurance policies, certain annuities, which may pass to heirs outside of probate, would only be subject to Medicaid recovery if a state expanded its definition of "estate."

Recovery of Medicaid payments may be made only after the death of the individual's surviving spouse, and only when there is no surviving child under age 21, or no surviving child who is blind or has a disability.[31] Estate recovery is limited to the amounts paid by Medicaid for services received by an individual and is limited to only those assets owned by the beneficiary at the time of recovery. As a result, estate recovery is generally applied to a beneficiary's home, if available, and certain other assets within a beneficiary's estate.

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[28] As of February 2005, two states had not yet implemented recovery programs (Georgia's state plan amendment is currently under the Centers for Medicare and Medicaid Services (CMS) review and Michigan has not submitted an amendment). In addition, two states have implemented recovery programs within the last three years (Arkansas and Texas). Source: The Congressional Research Service (CRS) telephone conversation with CMS in February 2005.

[29] Section 1917(b) of the Social Security Act.

[30] Section1917(b)(4) of the Social Security Act.

Exemptions From Recovery

Medicaid law, regulations and guidelines allow states to exempt certain Medicaid long-term care beneficiaries from estate recovery. These beneficiaries are:

- persons for whom the state has determined that recovery would impose an undue hardship (in accordance with standards specified by the Secretary of the Department of Health and Human Services, (DHHS);
- persons for whom the state has determined that recovery would not be cost-effective (subject to a methodology approved by the Secretary and written into the state plan); and
- persons who reside in either New York, Connecticut, California, Indiana, or Iowa and have received benefits under a state-approved long-term care insurance partnership policy.[32]

Collection Amounts for 2003

The amount of funds collected through states' recovery programs has been relatively small. In 2003, for example, the amount recovered from all states was approximately $337.2 million.[33] As a comparison, this amount represents about 0.8% of Medicaid's total nursing home expenditures in that year, totaling about $44.6 billion.[34] Although nursing home expenditures represent the largest service for which recovery is attempted, this comparison does not include expenditures on other eligible long-term care and related services or on eligible services rendered to younger persons with disabilities.

Despite this low recovery ratio overall, significant variation exists across states in terms of the amounts collected. **Table 1** shows the variation among states. With two exceptions, Arizona (9.9%) and Idaho (4.3%), amounts collected fall below 3% of states' nursing home expenditures.

In part these differences reflect variation in the political and economic environments across states. For example, states with more rigorous programs have tended to view estate recovery as a cost-containment strategy. Other states, particularly those with lower recovery ratios, might face barriers as a result of political debate about the appropriateness of recovering an individual's home after a beneficiary's death. In still others, particularly those with relatively low per capita income, a belief that recovery is not cost-effective in that state may contribute to weaker efforts to recover assets than might otherwise exist.

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[31] Section 1917(b)(2) of the Social Security Act.

[32] For more information about the Medicaid long-term care insurance partnership program, see CRS Report RL32610, *Long-Term Care Insurance Partnership Program*, by Julie Stone-Axelrad.

[33] Estate Recovery Amounts: State reported data on Third Party Liability Savings Trend Analysis 2003 at [http://www.cms.hhs.gov/medicaid/tpl/tplpart1.pdf].

[34] CRS analysis of state-reported data on CMS Form 64.

Table 1. Medicaid Estate Recovery Amounts as a Percent of Nursing Facility Expenditures in FY2003

State	Nursing facility expenditures (2003)	Estate recovery (2003)	Amount recovered as a percent of medicaid nursing facility expenditures)
Alabama	$768,429,449	$4,222,784	0.5%
Alaska	99,307,550	0	0
Arizona	22,317,755	2,200,444	9.9
Arkansas	540,164,919	1,730,100	0.3
California	2,931,814,408	44,024,077	1.5
Colorado	415,217,012	4,649,920	1.1
Connecticut	997,830,090	10,884,820	1.1
Delaware	152,539,852	1,108,545	0.7
Washington D.C.	192,937,448	1,658,606	0
Florida	2,126,718,331	11,474,485	0.5
Georgia	900,262,135	0	0
Hawaii	177,179,348	2,255,074	1.3
Idaho	125,414,776	5,357,412	4.3
Illinois	1,431,124,039	16,993,946	1.2
Indiana	762,160,704	7,366,747	1
Iowa	487,480,360	10,977,823	2.3
Kansas	35,1051,074	6,193,161	1.8
Kentucky	619,759,104	2,961,800	0.5
Louisiana	594,880,647	104,755	0
Maine	237,859,692	5,934,701	2.5
Maryland	801,725,424	6,919,915	0.9
Massachusetts	1,511,869,307	28,524,313	1.9
Michigan	999,090,959	0	0
Minnesota	930,440,562	18,300,218	2
Mississippi	503,630,708	168,735	0
Missouri	733,310,219	7,480,548	1
Montana	143,950,197	1,982,288	1.4
Nebraska	345,932,257	12,361,598	3.6
Nevada	111,198,439	not available	not available
New Hampshire	138,368,754	not available	not available
New Jersey	2,092,780,914	not available	not available
New Mexico	165,599,566	0	0
New York	7,121,191,662	27,244,711	0.4
North Carolina	892,644,843	4,053,121	0.5
North Dakota	171,627,898	1,684,666	1
Ohio	2,647,297,226	12,382,674	0.5
Oklahoma	438,007,880	1,873,304	0.4
Oregon	270,751,263	13,996,362	5.2
Pennsylvania	3,732,029,413	23,149,026	0.6
Rhode Island	265,937,326	3,559,076	1.3
South Carolina	418,286,025	5,150,428	1.2
South Dakota	130,053,431	1,293,813	1
Tennessee	918,785,385	4,156,333	0.5
Texas	1,835,713,376	0	0
Utah	104,652,074	459,400	0.4
Vermont	96,293,595	487,029	0.5
Virginia	615,543,238	953,406	0.2

State	Nursing facility expenditures (2003)	Estate recovery (2003)	Amount recovered as a percent of medicaid nursing facility expenditures)
Washington	623,752,430	5,816,188	0.9
West Virginia	330,832,100	1,183,754	0.4
Wisconsin	1,526,259,152	12,812,864	0.8
Wyoming	56,803,388	1,097,240	1
Total	$44,610,032,180	$337,190,210	0.8%

Sources: Nursing facility expenditures: CRS analysis of state-reported data on CMS Form 64. Estate Recovery Amounts: State reported data on Third Party Liability Savings Trend Analysis 2003, at [http://www.cms.hhs.gov/medicaid/tpl/tplpart1.pdf].

Medicaid Estate Planning

Medicaid's rules regarding eligibility, asset transfers, and estate recovery are designed to restrict access to Medicaid's long-term care services to people who are poor or have very high medical or long-term care expenses and who apply their income and assets toward the cost of their care. Despite Congress' efforts to discourage asset transfers, current law has not been able to preclude all available means for protecting assets. A variety of methods may still be used to protect assets from use toward an applicant's care and to enable applicants to qualify for Medicaid sooner than if they first spent their private resources on the cost of their care.

Asset Divestiture Techniques

The following are some examples of asset transfer and Medicaid estate planning methods that may be used to protect assets from use toward an applicant's care or from estate recovery. This list is not intended to be comprehensive:

- **Minimize the length of the penalty period.** There are a variety of ways in which one might transfer assets with the intention of shortening the penalty period. As explained above, the penalty period of ineligibility begins on the first day of the month in which assets are transferred. One option is to transfer a part of one's assets while using the remainder to pay for one's care until the penalty period expires.

One example of this method might be for a nursing home resident to divest half of his or her assets and retain the other half to pay for his or her care during the penalty period, such that once that remaining assets have been depleted on the cost of care, the penalty period would expire and the individual could obtain Medicaid coverage without delay. This method of transferring half of one's assets is referred to as the "half-a-loaf" strategy.

For example, a hypothetical person has $50,000 in assets and transfers $25,000 to a third party. The penalty period is calculated by dividing the amount of the transferred asset for less than fair market value by the cost of care in a private pay nursing home. If the monthly cost of care is $5,000, then the individual would be subject to five months of ineligibility for certain services ($25,000/$5,000=five months). During the five month period of ineligibility, that individual would apply the remaining $25,000 toward the cost of care. After five months, the individual would run out of funds at about the same time as the penalty period would expire. The individual could then apply to Medicaid and obtain coverage for his or her long-term care services.

- **Avoid the look-back period altogether.** Any transfers made at least 36 months before an individual applies for Medicaid coverage and 60 months for transfers that are defined as trusts under the law and regulations are not subject to a penalty because the transfer occurred before the beginning of the look-back period;

- **Convert countable assets into non-countable assets.** This is a process in which countable assets (e.g., funds in a savings account) may be converted into non-countable assets. For example, countable assets may be used to purchase an annuity for fair market value.[35] As long as the monthly income from the annuity, combined with all other sources of income, does not raise an individual's income above the eligibility thresholds, the existence of the annuity would not preclude an applicant from obtaining Medicaid coverage. Further, there is no federal requirement that the state be the beneficiary of the annuity. (See section on federal and state action for a more detailed discussion about annuities);

- **Establish irrevocable trusts.** The current look-back period for irrevocable trusts is five years. An applicant could place assets above Medicaid thresholds into an irrevocable trust in which an heir, and not the state, is named as a beneficiary without penalty if done so before the five year look back period. Such a method would protect all assets in the trust from use toward the cost of care and likely protect these assets from being subject to estate recovery;

- **Spend assets on items or services for fair market value.** Under current law, there are no restrictions on how assets above Medicaid thresholds may be used. If an individual who is applying for Medicaid has $8,000 above the asset threshold of $2,000, then that individual may choose to apply those excess funds toward the cost of his or her care or use these funds for home improvements, vehicle maintenance, entertainment, among others;

- **Use promissory notes.** As explained above, all transfers for less than fair market value are subject to penalties, except when made to certain third parties (e.g., spouse or disabled child). To transfer assets for less than fair market value to a non-permissible third party, one could use a promissory note in which the third party agrees to repay the amount of the transfer to the Medicaid applicant. In general, such promissary notes would be part of the person's probate estate, and thus subject to Medicaid estate recovery. However, anecdotal evidence suggests that not all promissory notes are repaid either to the Medicaid beneficiary or the state; or

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[35] OBRA '93 addressed annuities only tangentially by providing that the term "trust" includes an annuity only to such extent and in such manner as the Secretary of HHS specifies. Transmittal 64, or §3258.9(B) of the State Medicaid Manual, HCFA, No. 45-3, (Nov. 1994), provides the official CMS guidance on annuities. The guidance requires that annuities be actuarially sound, i.e., that the annuity pays back to the annuitant all of the funds used to purchase the annuity within that person's expected lifetime, otherwise the annuity will be considered a transfer of assets for less than fair market value and thus penalized. The CMS guidance attempted to "avoid penalizing annuities validly purchased as part of a retirement plan but to capture those annuities which abusively shelter assets." However, the CMS guidance does not state whether the payments must be monthly, or equal in size, or whether the remainder of the annuity can be paid to another person if the annuitant dies before the annuity is paid back. In addition, it is not clear under Transmittal 64 whether the purchase of an actuarially sound annuity is, by definition, a valid transfer of assets, regardless of the purchaser's intent.

- **Engage in sequential asset transfers.** As explained above, transfers to certain persons (e.g., a spouse or disabled or blind child) are permissible under the statute. Medicaid law, however, does not prevent these persons from transferring assets to other third parties, such as an adult non-disabled child or other relative, who are not specified in the law. Although states are permitted to take measures to review the financial records of eligible third parties, many do not. As a result, states do not generally monitor the financial records of persons who receive allowable transfers, leaving available the possibility that such persons might transfer those assets to another non-eligible third party.

There are a variety of other techniques that may be used as well, such as divorce in which the Medicaid applicant gives all assets and income to the community spouse; spousal refusal or abandonment in which a community spouse refuses to provide financial support for the institutionalized spouse; the creation of life estates; and giving gifts that fall below the transfer penalty amount (in states with such amounts) to separate individuals to avoid a penalty. The availability of these methods as a means of protecting assets is subject to state law and program rules.

State Action to Address Medicaid Estate Planning

States have attempted to discourage asset transfers within the guidance established by federal law. Using regulatory and program guidance authority, the Secretary has provided direction to states about its flexibility under federal law regarding asset transfers as well as providing additional parameters on the definitions of non-countable assets. For example, CMS has issued opinion letters to individuals requesting information on how federal law applies to particular state Medicaid rules on transfers of assets. In such letters (see, e.g., CMS letter to Michael J. Millonig, April 26, 2004), CMS has stated that states have considerable flexibility in administering their Medicaid programs and may validly make reasonable interpretations of federal law in areas that have not been specifically addressed in federal law, regulation or policy. In addition, CMS has advised states that they may add criteria to the determination of actuarially sound annuities or promissory notes, such as prohibiting balloon payments, or states may interpret gray areas of the law or areas where the law is silent.

States have also taken a number of measures to tighten asset transfer rules, although the design of these measures varies significantly across states. One example of states' efforts has been an attempt to restrict the use of Medicaid annuities. Some states have added criteria which must be met for the annuity to be considered actuarially sound. Examples of additional criteria include requiring that the payments be in equal monthly installments, that the annuity be purchased from a licensed commercial entity, that no one except the individual or his or her spouse benefit from the annuity, or that the annuity name the state as the first residual beneficiary of the annuity for a value up to the total amount expended by the state for the individual's care.

In addition, with regard to annuities, courts have come to differing conclusions on their treatment of whether, under the CMS guidance, a state may look at not only whether an annuity is "actuarially sound," but also whether the purpose of the annuity is to shelter assets to obtain Medicaid eligibility. In *Mertz v. Houston*, 155 F. Supp.2d 415 (E.D. Pa. 2001), for example, the court held that if an annuity was actuarially sound then the intent of the transfer was not relevant under federal law. However, in a recent Ohio case, a state court ruled that it was proper to look at the intent of asset transfers into an annuity, even if the annuity was actuarially sound. *Bateson v. Ohio Dept. of Job and Family* (Ohio Ct. App., 12th, No. CA2003-09-093, Nov. 22, 2004).

States have also attempted to further discourage estate planning by requesting approval to tighten asset transfer rules under Section 1115 waiver authority. Section 1115 of the Social Security Act provides the Secretary with broad authority to waive certain statutory requirements in the Medicaid program allowing states to conduct research and demonstration programs that further the goals of the Medicaid program. Connecticut, Minnesota, Massachusetts, and North Dakota are examples of states that have submitted waivers to the Secretary to do such things as lengthen the look back periods, change the date in which the penalty period begins, tighten rules on exempt assets, such as annuities, and place limitations on transfers to spouses, among others. Waivers for Minnesota, Massachusetts and North Dakota are pending approval. Connecticut recently withdrew its application.

Prevalence of Medicaid Estate Planning and Potential Cost Implications to the Medicaid Program

Although some careful analysis has been conducted to measure the prevalence of asset transfers, for the most part this analysis is based on data and case studies that are not recent or that are narrowly focused.[36] In addition, the prevalence of Medicaid estate planning as well as the types of methods used likely vary by state. None of these studies has been able to capture this variation. As a result, there are insufficient data available to accurately estimate the prevalence of asset transfers today and none that can reasonably predict whether or how much this prevalence might grow in the future.

The following is what we do know. We know that a significant amount of anecdotal evidence exists about persons engaging in Medicaid estate planning. We also know that an industry of elder lawyers specializing in Medicaid has developed across the nation. Court cases at federal and state levels also point toward the prevalence of transfers. In addition, we know that states have expressed a strong interest in curbing Medicaid estate planning and have taken a number of measures to try to do so.

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[36] Examples include E. O'Brien, (2005), *Medicaid's Coverage of Nursing Home Costs: Asset shelter for the wealthy or essential safety net*, Issue Brief: Georgetown University Long-Term Care Financing Project; A. Coates, M. Deily, F. Elig, G. Hoover, et al., (2003) The Role of Annuities in Medicaid Financial Planning: A Survey of State Medicaid Agencies. *American Public Human Services Association, National Association of State Medicaid Directors*; General Accounting Office (GAO): Health Education and Human Services Division, (1997). *Medicaid: Divestiture of Assets to Qualify for Long-Term Care Services B-277354.*

One question for which we do have information is the potential size of the pool of assets that could, but would not necessarily, be protected. A recent study [37] using data from the 2001 Survey of Income and Program Participation (SIPP) attempts to measure the total assets of unmarried elderly persons age 85 and older who are in need of assistance with functional limitations or cognitive impairments. In so doing, the study looks at two types of assets: the home and all assets other than the home, such as savings accounts, stocks and bonds, among others. The study found that the majority (84%) of this elderly population age 85 and older have assets, excluding home equity, that would enable them to cover one year of nursing home costs (at $70,000 per year); 9% have assets that could pay for one to three years of care; and 7% have assets that could cover at least three years of nursing home costs. The study shows that the wealth of the elderly population at risk for nursing home care is largely in home equity, and that the non-housing assets of this population are relatively small.

In addition, data collected by the U.S. Census Bureau from the 1996 SIPP panel survey show that almost half (49.8%) of the total net worth[38] of persons age 65 and older was in their own home and that this median net worth totaled $108,885 (in constant 2000 dollars).[39]

Within an environment of strained federal and state budgets, the logical next question is how much does Medicaid estate planning cost the Medicaid program. Although data are not available to accurately estimate the quantity of assets that have been protected, it is clear that any protection of assets that results in Medicaid paying for care that would otherwise have been paid with private funds results in increased costs to the Medicaid program. To the extent that legislative changes discourage asset protection and encourage persons to use private funds to pay for their own care, savings to Medicaid would result.

Given what we know, there is no indication that completely prohibiting asset transfers could result in savings that would amount to a large percentage of Medicaid program outlays. Furthermore, it is unlikely that any changes to current law could prohibit *all* of such transfers. Nonetheless, Medicaid spent $86.3 billion on long-term care services in 2003.[40] Even if only a fraction of spending were saved, it could be millions or possibly billions of dollars. In addition, as the population ages and the demand for long-term care grows, the potential financial strain on Medicaid will likely grow as well.[41] A political debate about the appropriate use of public dollars may help policymakers evaluate the various trade-offs that might be made between covering persons with long-term care needs of various wealth levels and using scarce Medicaid resources for other purposes.

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[37] Barbara Lyons, Andy Schneider, and Katherine A. Demond, "The Distribution of Assets in the Elderly Population Living in the Community," Kaiser Commission on Medicaid and the Uninsured, The Henry Kaiser Family Foundation, June 2005.

[38] Based on the value of all assets minus all liabilities and excluding equities in pension plans, the cash value of life insurance policies, and the value of home furnishings and jewelry.

[39] Source: Shawna Orzechowski, Peter Sepielli, "Net Worth and Asset Ownership of Households: 1998 and 2000," Current Population Reports, P70-88, Issued May 2003.

[40] CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS).

[41] See William F. Basset, *Medicaid's Nursing Home Coverage and Asset Transfers*, Board of Governors of the Federal Reserve System, Washington, D.C. Sent to CRS by the author in April 2005.

Appendix 1

Asset Rules Under SSI

Supplemental Security Income (SSI) is a federal program that provides monthly cash payments to people with limited income and resources who are age 65 or older, blind, or disabled. To qualify for SSI benefits, an individual (or a couple) must meet categorical criteria by being age 65 or older, blind, or disabled. They must also meet financial criteria by having *countable* resources below the SSI limit ($2,000 for an individual and $3,000 for a couple; these amounts are not indexed for inflation and have been at current levels since 1989) and *countable* income below the SSI benefit rate ($579 for an individual and $869 for a couple in 2005; these amounts are indexed annually for inflation and may be lower for individuals and couples living in someone else's household or in an institution).[42]

Federal regulations specify that for purposes of SSI, resources are cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.[43] Not all resources are counted in determining SSI eligibility. The value of an item may be totally or partially excluded when calculating countable resources. Couples receive the same resource (and income) exclusions as individuals (e.g., one automobile is excluded from countable resources for the couple as a whole, rather than one automobile for each member of the couple).

According to the Social Security Administration's most recent annual report on SSI, principal items that are excluded from countable resources include the following:[44]

- a home serving as the principal place of residence, regardless of value;
- life insurance policies whose total face value is no greater than $1,500;
- burial funds of $1,500 each for an individual and spouse (plus accrued interest);
- all household goods and personal effects;
- one automobile (if used for transportation for the individual, or for a member of the individual's household);[45]
- property essential to self-support (e.g., property used by an individual as an employee for work);
- resources set aside by an individual who has a disability or is blind to fulfill an approved Plan for Achieving Self-Support (PASS); and

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[42] In some cases the income and resources of others are also counted when determining SSI eligibility. This process is called deeming, and it applies when an eligible child lives with an ineligible parent, an eligible individual lives with an ineligible spouse, or an eligible alien has a sponsor.

[43] 20 CFR 416.1201(a).

[44] Social Security Administration, *SSI Annual Statistical Report, 2003*, Sept. 2004, pp. 3-4, available at [http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2003/ssi_asr03.pdf].

[45] Under former SSI rules, there were restrictions placed on the value of the automobile and household goods and personal effects that could be excluded from countable resources. As of March 9, 2005, one automobile and all household goods and personal effects are excluded, regardless of their value. See 70 *Federal Register* 6340, Feb. 7, 2005.

- amounts deposited into an individual development account (including matching funds and interest earned on such amounts) under the Temporary Assistance for Needy Families program or the Assets for Independence Act.

Table 1 provides a more comprehensive accounting of items (including those listed above) that are excluded from countable resources for purposes of determining SSI eligibility.

Table 1. Supplemental Security Income (SSI) Resource Exclusions

Exclusion	Limit on value or length of time?	Description
Home serving as the principal place of residence	No	A home is any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings. The home is not included in countable resources, regardless of its value. If an individual (and spouse, if any) moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. If an individual leaves his or her home to live in an institution, the home is still considered to be the individual's principal place of residence, irrespective of the individual's intent to return, as long as a spouse or dependent relative of the eligible individual continues to live there. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.
Funds from the sale of a home if reinvested timely in a replacement home	Yes	The proceeds from the sale of a home which is excluded from the individual's resources will also be excluded from resources to the extent they are intended to be used and are, in fact, used to purchase another home, which is similarly excluded, within three months of the date of receipt of the proceeds.
Nonliquid resources above the SSI resource limit if certain conditions are met	Yes	People with excess nonliquid resources generally cannot receive SSI benefits even if they meet all other eligibility requirements. As a result, they may have little or nothing on which to live while they look for a buyer for excess property. However, SSA has statutory authority to prescribe the period(s) within which and the manner in which to dispose of various kinds of property, and federal SSI regulations describe the conditions under which SSI payments can be made while an individual attempts to dispose of property. Such "conditional benefits" paid during this period are considered overpayments and must be repaid from the proceeds of the sale of excess resources. When the excess resources are in the form of real property which cannot be sold for certain specified reasons (undue hardship or unsuccessful reasonable efforts to sell, exclusions which are described later in this table), the owner can receive regular (not conditional) benefits. An individual (or couple) who meets all nonresource eligibility requirements, but fails to meet the resources requirement due solely to excess nonliquid resources, can receive SSI benefits based on a "conditional" exclusion of the excess nonliquid resources (lasting nine months for real property, and up to six months for personal property) if the individual/couple (or deemor) meets both of the following conditions: Countable liquid resources do not exceed three times the applicable federal SSI benefit rate (e.g., \$579/\$869 x 3 = \$1,737/\$2,607 in 2005) for an individual/couple. — The individual/couple agrees in writing to sell excess nonliquid resources at their current market value within a specified period and use the proceeds of sale to refund the conditional benefits (which are considered overpayments) they received.

Exclusion	Limit on value or length of time?	Description
Jointly owned real property which cannot be sold without undue hardship (due to loss of housing) to the other owner(s)	No	Excess real property which would otherwise be a resource is not a countable resource when it is jointly owned and sale of the property by an individual would cause the other owner undue hardship due to loss of housing. Undue hardship would result when the property serves as the principal place of residence for one (or more) of the other owners, sale of the property would result in loss of that residence, and no other housing would be readily available for the displaced other owner (e.g., the other owner does not own another house that is legally available for occupancy). However, if undue hardship ceases to exist, its value will be included in countable resources.
Real property for so long as the owner's reasonable efforts to sell it are unsuccessful	No	Real property that an individual has made reasonable but unsuccessful efforts to sell throughout a nine-month period of conditional benefits (see the"nonliquid resources above the SSI resource limit" exclusion described earlier in this table for an explanation of conditional benefits) will continue to be excluded for as long as: (1) the individual continues to make reasonable efforts to sell it and (2) including the property as a countable resource would result in a determination of excess resources. If the property is later sold, benefits paid during the nine-month conditional benefits period are subject to recovery as overpayments. Benefits paid beyond the nine-month period as a result of this exclusion are not subject to recovery as overpayments.
Restricted, allotted Indian land if the Indian/owner cannot dispose of the land without permission of other individuals, his/her tribe, or an agency of the federal government	No	In determining the resources of an individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, any interest of the individual (or spouse, if any) in land which is held in trust by the United States for an individual Indian or tribe, or which is held by an individual Indian or tribe and which can only be sold, transferred, or otherwise disposed of with the approval of other individuals, his or her tribe, or an agency of the federal government is excluded.
Life insurance, depending on its face value	Yes	In determining the resources of an individual (and spouse, if any), life insurance owned by the individual (and spouse, if any) will be considered to the extent of its cash surrender value. If, however, the total face value of all life insurance policies on any person does not exceed $1,500, no part of the cash surrender value of such life insurance will be taken into account in determining the resources of the individual (and spouse, if any). In determining the face value of life insurance on the individual (and spouse, if any), term insurance and burial insurance will not be taken into account.

Exclusion	Limit on value or length of time?	Description
Burial funds for an individual and/or his/her spouse	Yes	In determining the resources of an individual (and spouse, if any) there shall be excluded an amount not in excess of $1,500 each of funds specifically set aside for the burial expenses of the individual or the individual's spouse. This exclusion applies only if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual (or spouse) and are clearly designated as set aside for the individual's (or spouse's) burial expenses. If excluded burial funds are mixed with resources not intended for burial, the exclusion will not apply to any portion of the funds. This exclusion is in addition to the burial space exclusion.
Burial space or plot held for an eligible individual, his/her spouse, or member of his/her immediate family	No	In determining the resources of an individual, the value of burial spaces for the individual, the individual's spouse or any member of the individual's immediate family will be excluded from resources.
Household goods and personal effects	No	Household goods are not counted as a resource to an individual (and spouse, if any) if they are: (1) items of personal property, found in or near the home, that are used on a regular basis, or (2) items needed by the householder for maintenance, use and occupancy of the premises as a home. Such items include but are not limited to: furniture, appliances, electronic equipment such as personal computers and television sets, carpets, cooking and eating utensils, and dishes. Personal effects are not counted as resources to an individual (and spouse, if any) if they are: (1) items of personal property ordinarily worn or carried by the individual, or (2) articles otherwise having an intimate relation to the individual. Such items include but are not limited to: personal jewelry including wedding and engagement rings, personal care items, prosthetic devices, and educational or recreational items such as books or musical instruments. Items of cultural or religious significance and items required because of an individual's impairment also are not counted as resources to an individual. However, items that were acquired or are held for their value or as an investment are counted as resources because they are not considered to be personal effects. Such items can include but are not limited to: gems, jewelry that is not worn or held for family significance, or collectibles. Such items will be counted as a resource. (Prior to March 9, 2005, there were restrictions placed on the value of household goods and personal effects that could be excluded from countable resources. See *Federal Register* 70, no. 24, Feb. 7, 2005, pp. 6340-6345.)
One automobile	No	One automobile is totally excluded regardless of value if it is used for transportation for the individual or a member of the individual's household. Any other automobiles are considered to be nonliquid resources and are counted as a resource.

Exclusion	Limit on value or length of time?	Description
		(Prior to March 9, 2005, there were restrictions placed on the value of the automobile that could be excluded from countable resources. See *Federal Register* 70, no. 24, Feb. 7, 2005, pp. 6340-6345.)
Property essential to self-support	Yes	When counting the value of resources an individual (and spouse, if any) has, the value of property essential to self-support is not counted, within certain limits. There are different rules for considering this property depending on whether it is income-producing or not. Property essential to self-support can include real and personal property used in a trade or business, nonbusiness income-producing property, and property used to produce goods or services essential to an individual's daily activities. Liquid resources other than those used as part of a trade or business are not property essential to self-support. If the individual's principal place of residence qualifies under the home exclusion, it is not considered in evaluating property essential to self-support. Resources excluded under this provision generally fall into three categories: (1) Property excluded regardless of value or rate of return. This category encompasses: — property used in a trade or business (effective 5/1/90); — property that represents government authority to engage in an income producing activity; — property used by an individual as an employee for work (effective 5/ 1/90); and — property required by an employer for work (before 5/1/90). (2) Property excluded up to $6,000 equity, regardless of rate of return. This category includes nonbusiness property used to produce goods or services essential to daily activities. For example, it covers land used to produce vegetables or livestock solely for consumption by the individual's household. (3) Property excluded up to $6,000 equity if it produces a 6% rate of return. This category encompasses: — property used in a trade or business in the period before 5/1/90; and — nonbusiness income-producing property. However, the exclusion does not apply to equity in excess of $6,000 and does not apply if the property does not produce an annual return of at least 6% of the excluded equity. If there is more than one potentially excludable property, the rate of return requirement applies individually to each.
Resources of a blind or disabled person which are necessary to fulfill an approved Plan for Achieving Self-Support (PASS)	Yes	If the individual is blind or disabled, resources will not be counted that are identified as necessary to fulfill a plan for achieving self-support. A PASS must: (a) be designed especially for the individual; (b) be in writing; (c) be approved by the Social Security Administration (a change of plan must also be approved); (d) be designed for an initial period of not more than 18 months. The period may be extended for up to another 18 months if the individual cannot complete the plan in the first 18-month period. A total of up to 48 months may be allowed to fulfill a plan for a lengthy education or training program designed to make the individual self-supporting; (e) show the individual's specific occupational goal; (f) show what resources the individual

Exclusion	Limit on value or length of time?	Description
		has or will receive for purposes of the plan and how he or she will use them to attain his or her occupational goal; and (g) show how the resources the individual set aside under the plan will be kept identifiable from his or her other funds.
Stock held by native Alaskans in Alaska regional or village corporations	No	Shares of stock held by a native of Alaska (and spouse, if any) in a regional or village corporation were not counted as resources during the period of 20 years in which the stock was inalienable (nontransferable). Effective January 1, 1992, the stock became transferable and is treated as an excluded resource.
Federal disaster assistance received on account of a presidentially declared major disaster, including interest accumulated thereon	No	Assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States or comparable assistance received from a state or local government, or from a disaster assistance organization, is excluded in determining countable resources. Interest earned on the assistance is excluded from resources.
Retained retroactive SSI or Social Security Disability Insurance (SSDI) benefits	Yes	In determining the resources of an individual (and spouse, if any), the unspent portion of any Title II (SSDI) or Title XVI (SSI) retroactive payment received on or after 3/2/04 is excluded from resources for the nine calendar months following the month in which the individual receives the benefits. The unspent portion of retroactive SSI and SSDI benefits received before 3/2/04 is excluded from resources for the six calendar months following the month in which the individual receives the benefits.
Certain housing assistance	No	The value of any assistance paid with respect to a dwelling under: (1) the United States Housing Act of 1937; (2) the National Housing Act; (3) Section 101 of the Housing and Urban Development Act of 1965; (4) Title V of the Housing Act of 1949; or (5) Section 202(h) of the Housing Act of 1959 is excluded from resources.
Tax refunds related to the Earned Income Tax Credit (EITC) and Child Tax Credit (CTC)	Yes	In determining the resources of an individual (and spouse, if any), any unspent federal tax refund or payment made by an employer related to an EITC that is received on or after 3/2/04 is excluded from resources for the nine calendar months following the month the refund or payment is received. Any unspent federal tax refund or payment made by an employer related to an EITC that is received before 3/2/04 is excluded from resources only for the month following the month refund or payment is received. Any unspent federal tax refund from a CTC that is received on or after 3/2/04 is excluded from resources for the nine calendar months following the month the refund or payment is received. Any unspent federal tax refund from a CTC that is received before 3/2/04 is excluded from resources only for the month following the month the refund or payment is received. Interest earned on unspent tax refunds related to an EITC or a CTC is not excluded from resources.

Exclusion	Limit on value or length of time?	Description
Victims' compensation payments	Yes	In determining the resources of an individual (and spouse, if any), any amount received from a fund established by a state to aid victims of crime is excluded from resources for a period of nine months beginning with the month following the month of receipt. To receive the exclusion, the individual (or spouse) must demonstrate that any amount received was compensation for expenses incurred or losses suffered as the result of a crime.
State or local relocation assistance payments	Yes	Relocation assistance is provided to persons displaced by projects which acquire real property. In determining the resources of an individual (or spouse, if any), relocation assistance provided by a state or local government that is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by Section 216 of that Act is excluded from resources for a period of nine months beginning with the month following the month of receipt. Interest earned on unspent state or local relocation assistance payments is not excluded from resources.
Dedicated financial institution accounts required for past-due benefits paid to disabled children	No	In determining the resources of an individual (or spouse, if any), the funds in a dedicated financial institution account that is established and maintained for the payment of past-due benefits to disabled children will be excluded from resources. This exclusion applies only to benefits which must or may be deposited in such an account (specified in federal SSI regulations) and accrued interest or other earnings on these benefits. If these funds are commingled with any other funds (other than accumulated earnings or interest) this exclusion will not apply to any portion of the funds in the dedicated account.
Grants, scholarships, fellowships, and gifts used to pay for educational expenses	Yes	Effective June 1, 2004, there is a nine-month resource exclusion for grants, scholarships, fellowships, and gifts used to pay for tuition, fees, and other necessary educational expenses at any educational institution, including vocational and technical education.
Cash (including accrued interest) and in-kind replacement received from any source at any time to replace or repair lost, damaged, or stolen excluded resources	Yes	Cash (including any interest earned on the cash) or in-kind replacement received from any source for purposes of repairing or replacing an excluded resource that is lost, damaged, or stolen is excluded as a resource. This exclusion applies if the cash (and the interest) is used to repair or replace the excluded resource within nine months of the date the individual received the cash. Any of the cash (and interest) that is not used to repair or replace the excluded resource will be counted as a resource beginning with the month after the nine-month period expires. The initial nine-month time period will be extended for a reasonable period up to an additional nine months if the individual is found to have had good cause for not replacing or repairing the resource.
Certain items excluded from both income and resources under a federal statute other than the Social Security	Varies	In order for applicable payments and benefits received under a federal statute other than Title XVI of the Social Security Act (SSI) to be excluded from resources, the funds must be segregated and not commingled with other countable resources so that the excludable funds are identifiable.

Exclusion	Limit on value or length of time?	Description
Act		Examples of excluded payments include those relating to: Agent Orange; Austrian Social Insurance; Corporation for National and Community Service (CNCS) programs; Individual Development Accounts (IDAs) funded by the Temporary Assistance for Needy Families (TANF) program; demonstration project IDAs; Japanese-American and Aleutian restitution payments; energy assistance for low-income households; victims of Nazi persecution; the Netherlands' WUV program for victims of persecution; a Department of Defense (DOD) program for certain persons captured and interned by North Vietnam; the Radiation Exposure Compensation Trust Fund; the Ricky Ray Hemophilia Relief Fund; and veterans' children with certain birth defects. (For more information on these and other excluded payments and benefits, see 20 CFR 416.1236 and [http://policy.ssa.gov/poms.nsf/lnx/0501130050].)

Source: Congressional Research Service (CRS), based on 20 CFR 416.1201-1266; Social Security Administration (SSA), Program Operations Manual System (POMS), *Excluded Resources*, available at [http://policy.ssa.gov/poms.nsf/lnx/0501110210!opendocument]; SSA, POMS, *Guide to Resources Exclusions*, available at [http://policy.ssa.gov/poms.nsf/lnx/0501130050]; and SSA, *Social Security Handbook*, What are the Resource Exclusions?, available at [http://www.ssa.gov/OP_Home/handbook/handbook.21/handbook-2156.html].

Medicaid Payments For Prescription Drugs

Testimony of:
Robert A. Vito, Regional Inspector General
for Evaluation and Inspections, Philadelphia

Hearing Before:
Senate Committee on Finance
Charles E. Grassley, Chairman

June 29, 2005

Office of Inspector General
U.S. Department of Health and Human Services
Daniel R. Levinson, Inspector General

Testimony of:

Robert A. Vito

Regional Inspector General for Evaluation and Inspections, Philadelphia

Office of Inspector General, U.S. Department of Health and Human Services

Good morning, Mr. Chairman and members of the committee. I am Robert Vito, Regional Inspector General for Evaluation and Inspections in Philadelphia at the U.S. Department of Health and Human Services' Office of Inspector General (OIG). I appreciate the opportunity to appear before you today to present information regarding fraud and abuse in Medicaid prescription drug pricing.

In short, the Medicaid program is vulnerable to abuse and continues to pay too much for prescription drugs compared to prices available in the marketplace. My testimony begins by describing efforts to identify fraud and abuse involving prescription drugs in the Medicaid program, followed by an overview of OIG's work related to prescription drug pricing. This will include a discussion of new work, released today, which further reinforces our belief that Medicaid is paying too much for prescription drugs.

IDENTIFYING FRAUD AND ABUSE INVOLVING PRESCRIPTION DRUGS

OIG continues to place high priority on identifying and preventing fraud and abuse in Federal health care programs. One area of focus involves Medicare and Medicaid reimbursements for prescription drugs, where we have played a key role in rooting out fraud and abuse. Working closely with our many Federal and State partners, OIG has assisted in investigations that have resulted in significant civil and criminal monetary settlements.

Identifying and pursuing perpetrators of fraud and abuse depends on effective cooperation among a number of Federal and State agencies, as well as other partners. As you heard in testimony delivered yesterday, our office oversees the operations of the State Medicaid Fraud Control Units, which identify and develop cases of potential fraud and abuse.

Private citizens, whistleblowers, and other industry insiders are instrumental in identifying issues and assisting in investigations. They are often among the most knowledgeable sources of fraudulent or abusive activities. A notable example is a recent case initiated as a False Claims Act suit filed by three former employees of a Schering-Plough subsidiary. This case concluded when Schering-Plough Corporation agreed to pay almost $345.5 million as part of a global settlement with the Government to resolve administrative, civil, and criminal liabilities and entered into a corporate integrity agreement[1] with OIG. These liabilities occurred in connection with the alleged payment of kickbacks and the alleged failure to include the value of certain incentives offered to two HMOs in the company's determination of best price reported for purposes of the Medicaid drug rebate program, thereby resulting in the underpayment of rebates due to States and overcharges to health care entities, such as community health centers, that purchased drugs at ceiling prices based on Medicaid drug rebate prices. Appendix A contains a list of False Claims Act settlements with pharmaceutical manufacturers.

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[1] A provider or other entity that enters into a corporate integrity agreement commits to establish a compliance program and take other specified steps to ensure its future compliance with Federal health care program requirements.

MEDICAID PRESCRIPTION DRUG REIMBURSEMENT

The Centers for Medicare & Medicaid Services (CMS) estimates that Medicaid expenditures for prescription drugs in calendar year (CY) 2004 totaled more than $30 billion, a substantial increase over the $9 billion spent in CY 1994. Both the States and the Federal Government share in these expenditures. Under Federal law, States have substantial discretion in setting reimbursement rates for drugs covered under Medicaid. In general, Federal regulations require that each State's reimbursement for a drug not exceed the lower of the estimated acquisition cost plus a reasonable dispensing fee or the provider's usual and customary charge for the drug. In addition, CMS sets Federal upper limits and many States implement maximum allowable costs for certain multiple source (generic) drugs that meet specific criteria.

While States must reasonably reimburse pharmacies for prescription drugs provided to Medicaid beneficiaries, they often lack access to pharmacies' actual market prices. Due to this lack of data, they rely on estimates to determine Medicaid reimbursement. Most States base their calculation of estimated acquisition costs on published average wholesale prices (AWPs). AWPs (which are not defined by law or regulation) are compiled in drug compendia such as Medical Economics' *Red Book* and First Databank's *Blue Book.* As the findings of our reports have consistently demonstrated, the published AWPs that States use to determine their Medicaid drug reimbursement amounts generally bear little resemblance to the prices incurred by retail pharmacies.

Until the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Medicare Part B also used AWP as the basis for most drug reimbursements. Based upon provisions in the MMA, Medicare Part B now generally uses Average Sales Price (ASP), a statutorily defined price based on actual sales transactions. While Congress's recent action helped lower excessive payment levels in Part B, Medicaid's reimbursement methodology continues to be based largely on the same inflated AWPs that once plagued Medicare.

Medicaid Pays Too Much for Prescription Drugs

Previous OIG work has revealed that Medicaid reimbursement for prescription drugs often exceeds pharmacies' actual acquisition costs. Our analysis comparing actual pharmacy acquisition costs to AWP for calendar year 1999 revealed that pharmacy acquisition costs for brand name and generic drugs were 21.8 percent and 65.9 percent below AWP, respectively. At that time, States, on average, reimbursed for drugs at AWP minus 10.3 percent. The 1999 estimates were higher than our previous studies of 1994 data, which showed that acquisition costs were 18.3 percent below AWP for brands and 42.5 percent below AWP for generics.[2] We estimated that the difference between actual acquisition costs and the amount the Medicaid program would have paid using the States' average estimated acquisition cost formulas was $1.5 billion in 1999.[3]

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[2] Medicaid Pharmacy – Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products (A-06-02-00041).

Today, we are releasing two reports that further indicate that the published prices that Medicaid uses to calculate reimbursement amounts for prescription drugs do not approximate pharmacy acquisition costs. The first report, *Medicaid Drug Price Comparisons: Average Manufacturer Price to Medicaid List Prices*, compares Average Manufacturer Price (AMP), a statutorily defined sales-based price used in determining Medicaid drug rebates, to published prices such as AWP and Wholesale Acquisition Cost (WAC). The second report, *Medicaid Drug Price Comparison: Average Sales Price to Average Wholesale Price*, compares ASP, a statutorily defined price based on actual sales transactions used to determine reimbursement for Medicare Part B covered prescription drugs, to AWP. Both reports are available on our Web site, http://oig.hhs.gov.

Overall, these inspections found that statutorily defined prices based on actual sales (i.e., AMP and ASP) are substantially lower than published prices (i.e., AWP and WAC). Statutorily defined prices are also lower than States' estimated acquisition cost formulas, which are based on AWP and WAC. These differences are particularly large for generic drugs.

For Medicaid-reimbursed drugs overall, AMP is 59 percent lower than AWP at the median. In contrast, the median State estimated acquisition cost formula is AWP minus 12 percent. We also found that AMP is 25 percent lower than WAC at the median. Among the States that use WAC to estimate pharmacy acquisition cost, the median State formula is WAC plus 8.5 percent.

While AMP is 59 percent lower than AWP overall, the disparity between AMP and AWP is substantially larger for generic drugs than for brand name drugs. We found that for generic drugs, AMP is 70 percent lower than AWP at the median. In comparison, AMP is 23 percent lower than AWP for single source brands, and 28 percent lower than AWP for multisource brands at the median.

This pattern also held true when we compared ASP to AWP for drugs covered by Medicare Part B. For generic drugs, ASP is 68 percent lower than AWP at the median. In comparison, ASP is 26 percent lower than AWP for single-source brands and 30 percent lower than AWP for multisource brands at the median.

OIG has recommended that Medicaid should base reimbursement on pricing data that more accurately reflect actual acquisition costs. These inspections provide additional evidence that published prices are higher than prices based on actual sales transactions. The substantial disparities between prices based on actual sales (AMP and ASP) and the published prices currently being used indicate that changing the basis of Medicaid reimbursement could have a significant impact on Medicaid expenditures.

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[3] Estimate from analyses of data contained in the following reports: Medicaid Pharmacy - Actual Acquisition Cost of Brand Name Prescription Drug Products (A-06-00-00023); and Medicaid Pharmacy - Actual Acquisition Cost of Generic Prescription Drug Products (A-06-01-00053).

Missed Savings Opportunities for the Federal Upper Limit Program

The Federal upper limit program was created to help ensure that Medicaid acts as a prudent payer by taking advantage of current market prices for lower-cost generic drugs. For multiple source (generic) drugs, Medicaid generally limits reimbursement to Federal upper limit amounts if certain criteria are met (42 CFR § 447.332).

For the Federal upper limit program to truly take advantage of market prices for generic drugs, two conditions must be met: (1) qualified drugs must be added to the Federal upper limit list in a timely manner, and (2) the prices used to determine Federal upper limits must accurately reflect pharmacy acquisition costs. Previous OIG work has identified problems with regard to timely placement of qualified generic drugs onto the Federal upper limit list. Our current work, which we are releasing today, focuses on the basis for setting Federal upper limit amounts.

Medicaid misses savings opportunities when qualified drugs are not placed on the Federal upper limit list in a timely manner. Previous OIG work has quantified the missed savings opportunities when qualified drugs are not included when they first become eligible. In a report issued in February 2004, we reported that 90 drugs were not included on the list despite meeting the criteria established by Federal law and regulation. We estimated that Medicaid could have saved $123 million in 2001 if CMS had added just 55 of these 90 products to the Federal upper limit list. Four products alone accounted for 71 percent of the $123 million in potential savings. By the end of 2003, CMS had added 9 of the 90 products to the Federal upper limit list. Seven of the nine products accounted for $94 million of the $123 million in savings calculated for 2001.

In follow-up work requested by the House Committee on Energy and Commerce and released in December 2004, we again found that CMS did not consistently add qualified drugs to the Federal upper limit list in a timely manner. Of the 252 first-time generic drugs approved between 2001 and 2003, 109 products met the statutory and regulatory criteria for inclusion on the list. CMS had added only 25 of the 109 drugs to the list as of July 15, 2004, and very few of these were included in a timely manner. It took CMS an average of 36 weeks to place these products on the list once they became eligible for inclusion. Delays in adding the reviewed drugs cost the Medicaid program an estimated $167 million between 2001 and 2003. The Federal share of the $167 million was approximately $95.5 million.

One of the reports we are releasing today, *Comparison of Medicaid Federal Upper Limit Amounts to Average Manufacturer Prices*, we compare the Federal upper limit price of more than 400 generic drugs to the AMP amount. We found that current Federal upper limit amounts substantially exceed AMPs.

Federal regulation sets the Federal upper limit amount for a qualified drug at 150 percent of the lowest price published in the compendia (i.e., 150 percent of the lowest AWP or WAC) plus a dispensing fee. However, as we have repeatedly found, these published prices do not approximate actual pharmacy acquisition costs.

Each Federal upper limit amount applies to a group of at least three drugs (i.e., therapeutically equivalent drugs that meet specified criteria). Overall, we found that Federal upper limit amounts were five times greater than the average AMP for these groups of equivalent generic drug products. Among individual generic drug products, Federal upper limits exceeded average AMPs by as much as 19 times. We also compared Federal upper limit amounts to the minimum AMPs reported by drug manufacturers. Compared to the minimum AMPs among generic products, Federal upper limit amounts were 22 times higher. For 29 drug products, Federal upper limit amounts were at least 40 times the minimum reported AMPs.

Based on these pricing differences, we estimate that the Medicaid program could have saved $161 million in the third quarter of 2004 by setting reimbursement at 150 percent of the average AMP, rather than 150 percent of the lowest published price. If the Federal upper limit were based on 150 percent of the minimum reported AMP, the program could have saved up to $300 million during that same period. These findings reinforce previous recommendations that reimbursement formulas based on prices that more closely approximate acquisition costs could save substantial amounts in the Medicaid program.

State Variations in Reimbursements for the Same Drugs

As previously mentioned, States have wide latitude in setting their reimbursement amounts for prescription drugs. In September 2004, we issued a report of a study in which we assessed the extent to which States vary in their Medicaid reimbursement for the same drugs.

Based on State data, we estimated that, overall, Medicaid could have saved as much as $86.7 million in fiscal year 2001 if the 42 States in our analysis had reimbursed at the same price as the lowest paying State for each of the drugs reviewed. In fact, for nine drugs Medicaid could have cut its spending by more than half if all States had paid the same price as the lowest paying State. The total savings estimate is derived from only 28 national drug codes that were randomly selected from 600 national drug codes for which there were substantial Medicaid outlays.

We believe savings could be achieved if CMS would: (1) share with the States the various types of price data it collects, including AMP, to help States develop better estimates of pharmacy acquisition costs, (2) conduct further research on the factors that affect States' drug prices to be able to advise States more effectively on ways to set their reimbursement levels, and (3) annually review the States' drug prices in order to share AMPs and methods to reduce costs.

MEDICAID DRUG REBATE PROGRAM

State Accounting for Rebate Billings and Collections

In addition to paying too much up front for Medicaid prescription drugs, States exacerbate their overspending of State and Federal funds by poor management of their rebate billings and collections. Pursuant to the Medicaid drug rebate statute and the rebate agreements entered by manufacturers, States collect rebates from drug manufacturers for drug reimbursements made under the Medicaid program. The drug rebate program allows Medicaid to receive pricing benefits commensurate with its position as a high-volume payor of prescription drugs.

Shortly after the statutory drug rebate program became effective in January 1991, we audited the effectiveness of the new program in eight States. We found that CMS had not ensured that States had established proper accountability and controls over the billing and collection of drug rebates. In addition, CMS could not develop a nationwide total of the uncollected portion of Medicaid drug rebates because States were only required to report the rebates that were collected. We replicated our review recently on a national scale, using 2002 data, and found that while accountability had improved since our 1993 report, improvements are needed in most States. Weaknesses included the following:

- Rebate accounting systems were inadequate.
- Information submitted to CMS was unreliable, undermining CMS's ability to oversee the program.
- Accounting for interest on late rebate payments was improper.
- Dispute resolution and collection processes were inadequate.

We are in the process of developing a national roll-up report. The individual final reports for each State and the District of Columbia are currently available on our Web site.

Drug Rebate Calculations

Additional Medicaid overspending occurs because of an inconsistency between the key values used for calculating rebates and reimbursements. Currently, Medicaid requires that rebates be based on specifically designated values, one of which is AMP. At the same time, most States do not have access to AMP data and instead use AWP for reimbursement. This creates a situation whereby fluctuations in reimbursements do not result in corresponding adjustments in the associated rebates. When a State increases its reimbursement amount for a drug, it does not receive a correspondingly higher rebate on that drug purchase because there is currently no connection between the reimbursement and rebate calculations.

In a 1998 report, we recommended that CMS seek legislation requiring drug manufacturers to pay Medicaid drug rebates on the same basis that States determine reimbursements. If rebates had been calculated based on AWP, rather than on the statutorily required AMP, Medicaid would have achieved over $1 billion in added rebates for calendar years 1994 through 1996. We used AWP to calculate the rebates for the period because most States were basing drug reimbursements on AWP minus a percentage discount. According to information States have reported to CMS, most States continue to use AWP in their reimbursement methodologies. If Congress established a specific basis for calculating Medicaid prescription drug acquisition costs, the same basis should be used for calculating rebates.

Manufacturers' Calculation of AMP

The AMP is statutorily defined and represents the price at which manufacturers sell their drugs to wholesalers for use in the retail class of trade. CMS has not issued final regulations to further define AMP. Our audit work at selected manufacturers has shown that they are making inconsistent interpretations as to what components are included in AMP. The inconsistencies have included how to treat Medicaid sales and accounting for sales and price concessions that flow through organizations representing both retail and nonretail customers. It is important that all manufacturers report consistent and accurate information for the rebate process to work as intended. We therefore continue to suggest that CMS provide additional instruction about the definition of AMP. This would both improve the rebate process and assist States in using AMP data to estimate pharmacy acquisition costs for reimbursement purposes if States gain access to AMP data.

THIRD-PARTY LIABILITY

Another area of concern regarding Medicaid payments for prescription drugs involves issues with recouping money owed by liable third parties. Millions of Medicaid beneficiaries have additional health insurance through third-party sources such as Medicare or private health plans. Because Medicaid is required by law to be the payer of last resort, these third parties are often liable for many prescription drug claims submitted to Medicaid. When State Medicaid agencies receive claims that have a liable third-party payer, they can (1) cost avoid, i.e., return the claim to the provider so that the provider can bill the liable third party, or (2) pay and chase, i.e., pay the provider's claim and then seek recovery from the liable third party. States are required to use cost avoidance for most services unless the State obtains a waiver from CMS allowing it to pay and chase. States report cost-avoidance and pay-and-chase collections data to CMS. States are not required to report the amount they attempted to recover from liable third parties.

Federal regulations require that for a waiver to be approved, States must demonstrate that the pay-and-chase approach is as cost effective as the cost-avoidance approach. Our previous work has found that CMS regional offices often approve waivers without considering cost effectiveness. In an OIG report released in August 2001, we found that 32 States were at risk of losing over 80 percent ($367 million) of Medicaid pharmacy payments they tried to recover from third parties through the pay-and-chase approach. Almost three-quarters of States we contacted reported facing difficulties recovering payments from third parties.

In addition to procedural recommendations, we suggested that CMS determine whether legislation is needed to (1) explicitly include pharmacy benefit management companies in the Medicaid program's definition of a third party, (2) require third parties to match their eligibility files with Medicaid's eligibility files, and (3) allow Medicaid up to 3 years to recover payments from liable third parties. CMS generally concurred with our recommendations and reports that it has taken steps to limit the use of the pay-and-chase approach.

CONCLUSION

Based on years of work by OIG, the U.S. Government Accountability Office, and others revealing that AWP exceeds actual acquisition costs, the Medicare program eliminated the use of AWP in its pricing methodology for Part B covered drugs. However, in the Medicaid program, most States still use AWP when setting drug reimbursement amounts. In addition, the Medicaid Federal upper limit program, which was intended to take advantage of lower prices for generic products, also bases reimbursement on inflated published prices such as AWP and WAC. The Medicaid program could achieve substantial savings if Medicaid based drug reimbursement on accurate pricing information. We believe that Medicaid drug reimbursement should be fair and accurate. Drug reimbursement should reliably reflect the actual costs of drugs to pharmacies and be based on pricing data that can be validated. Neither of these criteria applies to AWP or WAC. There is an urgent need for the Medicaid policymaking community to assist States in strengthening their ability to make reasonable payments for Medicaid-covered drugs. For our part, OIG is committed to continue working with its many partners to help prevent fraud and abuse in the Medicaid program.

This concludes my testimony, and I welcome your questions.

Appendix A

Medicaid-Related Prescription Drug Settlements Settlements with Pharmaceutical Manufacturers

Recent Federal investigations of pharmaceutical manufacturers that led to settlements involving Medicaid prescription drug cases serve to illustrate weaknesses and vulnerabilities in the Medicaid drug reimbursement arena. Following are descriptions of some, but not all, relevant cases. Both the United States and individual States have negotiated other settlements that are not mentioned here.

The OIG's "Compliance Program Guidance for Pharmaceutical Manufacturers" is available on the OIG Web site at http://www.oig.hhs.gov/fraud/complianceguidance.html.

Schering-Plough Corporation. In 2004, Schering-Plough Corporation agreed to pay almost $345.5 million as part of a global settlement with the Government and entered a 5-year corporate integrity agreement (CIA) with the OIG. As part of the settlement, Schering-Plough agreed to pay almost $293 million to resolve its civil and administrative liabilities in connection with illegal and fraudulent pricing of its allergy drug Claritin under the Medicaid drug rebate program. The civil portion of the case focused on Schering-Plough's alleged failure to include the value of certain incentives offered to two managed care organizations in Schering-Plough's determination of the best price reported for purposes of the Medicaid drug rebate program. By failing to include the value of the incentives in its determination of best price, Schering-Plough allegedly underpaid rebates due to the States and overcharged entities (such as community health centers) that purchased drugs at ceiling prices that are based on Medicaid drug rebate prices. With regard to the criminal portion of the case, a subsidiary of Schering-Plough, the Schering Sales Corporation, pled guilty to a kickback charge and was sentenced to pay a $52.5 million criminal fine. Schering Sales Corporation was charged with paying a kickback of almost $2 million in order to keep Claritin on the formulary of a managed care organization.

Pfizer Inc. As part of a fiscal year 2004 global settlement of $430 million plus interest, Pfizer Inc. (Pfizer), Warner-Lambert Company LLC (Warner-Lambert), and the Parke-Davis Division agreed to pay $190 million in a civil False Claims Act settlement relating to Warner-Lambert's promotion of the drug Neurontin. Pfizer acquired Warner-Lambert and its Parke-Davis Division in June 2000. Between July 1995 and June 2001, Neurontin was approved by FDA only for use in treating epilepsy, but Warner-Lambert allegedly engaged in a wide-ranging program to promote Neurontin for other uses. The Government alleges that these activities caused the submission of false and/or fraudulent claims to Medicaid. To resolve its criminal liability, Warner-Lambert pled guilty to violating the Federal Food, Drug and Cosmetic Act and agreed to pay a $240 million criminal fine. Pfizer entered a comprehensive 5-year corporate integrity agreement with OIG.

AstraZeneca Pharmaceuticals, LP and Zeneca Inc. In June 2003, the United States announced a global settlement with AstraZeneca. The company agreed to pay a total of almost $355 million and enter a 5-year CIA with OIG to resolve its criminal and civil liabilities relating to the marketing and pricing of its prostate cancer drug, Zoladex. AstraZeneca pled guilty to conspiracy to violate the Prescription Drug Marketing Act by causing the submission of reimbursement claims for Zoladex that had been provided free of charge as samples. The Government also alleged that AstraZeneca paid illegal remuneration (in various forms including grants, travel, and entertainment) to induce the purchase of Zoladex; that AstraZeneca created and marketed an average wholesale price (AWP) spread between the Medicare reimbursement for Zoladex and its cost; and that AstraZeneca misreported and underpaid Medicaid rebates for Zoladex. AstraZeneca also agreed to enter separate settlements with the States.

Bayer Corporation. In April 2003, Bayer Corporation agreed to pay $257.2 million in criminal fines and civil assessments to settle a False Claims Act case relating to the Medicaid drug rebate program. Bayer agreed to plead guilty to charges that it violated Federal law by failing to report certain information to FDA. The case focused on Bayer's failure to include certain sales to Kaiser Permanente Medical Care (an HMO) in its calculation of Best Price reported for purposes of the Medicaid drug rebate program. The Medicaid drug rebate program requires drug manufacturers to report their Best Prices to CMS and to pay rebates to the State Medicaid programs based on those reported prices.

GlaxoSmithKline. Also in April 2003, GlaxoSmithKline settled a Medicaid drug rebate case for almost $88 million, based on facts similar to the Bayer matter discussed above. In connection with the settlement, GlaxoSmithKline entered a 5-year CIA with OIG. GlaxoSmithKline also agreed to enter into separate settlement agreements with the States.

Pfizer, Inc. In October 2002, the United States settled a Medicaid drug rebate case with Pfizer, Inc., Warner-Lambert Company and the Parke-Davis Division. The Government alleged that Warner-Lambert failed to include the value of certain unrestricted educational grants in the Best Price reported for purposes of the Medicaid drug rebate program and, as a result, underpaid rebates due. The government alleged that Warner-Lambert paid the grants to a managed care organization in order to obtain unrestricted formulary status for the cholesterol-lowering drug, Lipitor. As part of the settlement, Pfizer paid $49 million and entered a five-year CIA with OIG.

TAP Pharmaceutical Products, Inc. In October 2001, the United States announced a major global health care fraud settlement with TAP Pharmaceutical Products Inc. TAP agreed to pay a total of $875 million to resolve its liabilities. TAP agreed to plead guilty to violating Federal law governing the use of drug samples. In addition, TAP allegedly set and reported AWPs for its prostate cancer drug, Lupron, at levels far higher than the actual acquisition cost of the majority of its customers (such as physicians) and caused those customers to receive excess reimbursement from Medicare and Medicaid. TAP also allegedly paid kickbacks to induce the purchase of Lupron and underpaid rebate amounts due to the States under the Medicaid drug rebate statute. TAP entered a seven-year CIA with OIG.

Bayer Corporation. In February 2001, the United States entered a $14 million settlement with Bayer Corporation in connection with Bayer's AWP pricing and Medicaid drug rebate practices relating to six drugs. The Government alleged that Bayer set and reported AWPs for the drugs at levels far higher than the actual acquisition costs of the products; that Bayer made misrepresentations to the Medicaid programs of certain States; and knowingly misreported and underpaid Medicaid rebates for the drugs. As part of the settlement, Bayer entered a five-year CIA with OIG.

Appendix B

Selected Medicaid Drug Reports Available on the OIG Web Site
(http://www.oig.hhs.gov)

A-06-91-00092 May 1992	HCFA Needs to Provide Additional Guidance to Drug Manufacturers To Better Implement the Medicaid Drug Rebate Program. (Inconsistencies in manufacturers methods used to determine AMP.)
A-06-91-00102 April 1992	Improvements Needed in HCFA's Procedures To Implement the Medicaid Drug Rebate Program. (Errors in AMP and best price.)
A-06-92-00029 June 1993	Management Controls Over the Medicaid Drug Rebate Program. (Inadequate State controls and accountability over billing and collection of rebates.)
A-06-96-00030 April 1997	Medicaid Pharmacy: Actual Acquisition Cost of Prescription Drug Products for Brand Name Drugs. (Based on invoices, in 1994 pharmacy acquisition costs for brand name drugs averaged 18.3 percent below AWP.)
A-06-97-00011 August 1997	Medicaid Pharmacy - Actual Acquisition Cost of Generic Prescription Drug Products. (Based on invoices, in 1994 pharmacy acquisition costs for generic drugs averaged 42.5 percent below AWP.)
OEI-05-99-00611 July 2001	Containment of Medicaid HIV/AIDS Drug Expenditures. (Comparison of Medicaid payments to other pricing methods.)
A-06-97-00052 May 1998	Need to Establish Connection Between the Calculation of Medicaid Drug Rebates and Reimbursement for Medicaid Drugs. (Increases in reimbursement do not trigger corresponding increases in rebates.)
A-06-00-00023 August 2001	Actual Acquisition Cost of Brand Name Prescription Drug Products. (Based on invoices, in 1999 pharmacy acquisition costs for brand name drugs averaged 21.84 percent below AWP.)
OEI-03-00-00030 August 2001	Medicaid Recovery of Pharmacy Payments from Liable Third Parties. ($367 million of unrecovered Medicaid pharmacy payments at risk.)
OEI-03-01-00010 September 2001	Medicaid's Use of Revised Average Wholesale Prices. (States' use of price revisions by First Databank.)
A-06-01-00053 March 2002	Medicaid Pharmacy - Actual Acquisition Cost of Generic Prescription Drug Products. (Based on invoices, in 1999 pharmacy acquisition costs for generic drugs averaged 65.93 percent below AWP.)
A-06-02-00041 September 2002	Medicaid Pharmacy - Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products. (A 4-tier discounting methodology would bring reimbursement more in line with acquisition costs.)

OEI-05-02-00080 August 2003	Medicaid's Mental Health Drug Expenditures. (Comparison of Medicaid payments to 4 other Federal payers.)
OEI-05-02-00680 October 2003	State Strategies to Contain Medicaid Drug Costs. (Review of States' methods to control spending on drugs.)
OEI-03-02-00670 February 2004	Omission of Drugs from the Federal Upper Limit List in 2001. (CMS did not ensure timely placement of drugs on the FUL list.)
OEI-03-02-00660 April 2004	Medicaid Rebates for Physician-Administered Drugs. (Some States' systems are inadequate to ensure rebate collections.)
OEI-05-02-00681 September 2004	Variation in State Medicaid Drug Prices. (States' reimbursements vary widely for the same drugs.)
OEI-03-04-00320 December 2004	Addition of Qualified Drugs to the Medicaid Federal Upper Limit List. (CMS did not ensure timely placement of drugs on the FUL list.)
OEI-03-05-00200 June 2005	Medicaid Drug Price Comparison: Average Sales Price to Average Wholesale Price. (Medicaid reimbursement based on AWP greatly exceeds what Medicaid would otherwise pay if reimbursement were based on ASP.)
OEI-05-05-00240 June 2005	Medicaid Drug Price Comparisons: Average Manufacturer Price to Published Prices. (Medicaid reimbursement based on published prices greatly exceeds what Medicaid would otherwise pay if reimbursement were based on AMP.)
OEI-03-05-00110 June 2005	Comparison of Medicaid Federal Upper Limit Amounts to Average Manufacturer Prices. (Medicaid reimbursement for prescription drugs on the FUL list greatly exceeds what Medicaid would otherwise pay if FUL were based on AMP.

Statement of Timothy M. Westmoreland
Visiting Professor of Law, Research Professor of Public Policy
Georgetown University
Before the Committee on Finance
U.S. Senate
June 28, 2005

Mr. Chairman and Members of the Committee:

Thank you for the invitation to testify today. Preparing for this hearing, I realized that it has been almost five years since I was last here. It's good to be back.

Medicaid in Context: Playing Catch-Up for the Broken Health Care System

We must discuss the issues of this hearing within the larger context of Medicaid policy: Why is Medicaid so expensive and why is it growing so fast? The answer is that Medicaid is doing the "catch-up" work for the whole broken health care system in the U.S.

- Medicaid must play catch-up for the omissions of Federal Medicare policy.
  - Medicaid bears the $100 billion annual costs of inadequate coverage and benefits in Medicare for the seven million dually eligible people.
  - Medicaid also bears the $10 annual billion costs of those people who are waiting to be duals and who have only Medicaid while sitting through Medicare's two-year waiting period.
- Medicaid is also playing catch-up for the changes in the private health insurance market.
  - Employers—especially small employers—are increasingly finding that the costs of providing insurance are unaffordable.
  - Employees are also finding that they cannot afford the rising premiums, which are growing much faster than income.
  - The population is increasing in geographic areas that have not had high rates of private insurance.
  - And the weak economy has meant that more people are poor.
- Medicaid is also playing catch-up for the accelerating costs of health care, especially prescription drugs and long-term care, for both of which Medicaid is the largest payor in the country.
- And Medicaid is playing catch-up as virtually the only insurer for people with chronic illnesses and disabilities.
  - Private insurers don't want to cover these people and actively underwrite to avoid them.
  - And neither Medicare nor private insurance provides the benefits that people of all ages with disabilities need.

Note: The views expressed are my own and should not be construed to represent past, present, or future employers.

- This valuable work of Medicaid has been clearly recognized by your work, Mr. Chairman, to make sure that more children with disabilities can be made eligible for the program. I hope that the Family Opportunity Act, for instance, can make it into law this year.

Given all the work that we have asked the program to do, how many problems it is handling for other parts of the health system, and how vulnerable its beneficiaries are, it is performing flexibly and well--and, I would note, efficiently, with fewer overhead costs than private insurers who deal with a much less difficult job.

Protecting Against Abuse of Medicaid

I am certain that the program includes waste and fraud and problems of financial integrity. I defer to my colleagues on this panel to describe these abuses in detail, but one need look no further than the appendices of the recent OIG semiannual report or the case docket of TAF to see the hundreds of millions of dollars that are at stake every year.

This is not unique to Medicaid: No program of this size can avoid attracting people who would abuse it. I am against these abuses, and I take backseat to no one in my work against them. We should fix them as we find them—both to ensure that the public continues to trust the program as efficient and responsive and to reinvest the money that is saved back into the good work of Medicaid.

Such a prudent course of ferreting out abuse and plowing the savings back into Medicaid is especially needed now because the program is seriously under-financed. Many States are still in economic and fiscal and distress. On top of that, more than two dozen States (many represented by Members of this Committee) will have their Federal matching rates lowered this year and even more will next year. States are feeling the pressure and are making serious cuts in eligibility and services. Hundreds of thousands of poor people are being cut off of Medicaid because of State retrenchments. One State wants to limit people to two prescription drugs a month—no matter how sick they are. Another has proposed eliminating coverage of oxygen. And, of course, the Medicare clawback will only perpetuate and exacerbate these funding problems.

While Medicaid is doing hard work credibly, it is an extremely strained system, especially from a State perspective. The Federal government should, therefore, be careful about making big changes or fast moves. So much is at stake—the safety net under the rest of American health care—that none of us will be unaffected if the system is pressed too hard.

This is why I find the way that the current Administration is now dealing with State financing systems so troubling. Let me provide a little background.

The Example of Aggregated Upper Payment Limits (UPL)

As I mentioned, I was before this Committee five years ago. I was testifying as the Federal director of the Medicaid program. I had found out about a State financing system that I believed was inappropriate—aggregated upper payment limits, or the so-called UPL. I was trying to issue a regulation to close abusive UPL schemes down.

UPL was complicated and it was big. The Congressional Budget Office had informally estimated that, if left unchanged, UPL alone would raise Federal costs by more than $100 billion.

But we dealt with it correctly and transparently.

- We made our views about UPL clear in advance.
- We met with the Office of the Inspector General and with the General Accounting Office and briefed them about the problems we had found and about our proposed solutions. We asked them for their help and we worked together.
- We met with the governors, with the State legislatures, with hospitals, and with advocates.
- We met repeatedly with Congressional staff and kept them apprised of our work.
- We published a proposed regulation, solicited comments on it, and made the regulation final as a clear and enforceable statement of law.
- We gave States notice of the new regulation and we gave them a transition period to change their systems.
- And we effectively closed down the abuses of UPL. Some estimates show that UPL spending is now down 90% from its high point, and I am happy to see that the recent OIG report estimates that our actions resulted in $5 billion in Federal savings in this year alone—five years after we finished our work.

The Ad-hoc, Non-transparent Practices of the Current Administration's Review of Medicaid Financing

In dealing with State financing of Medicaid, this Administration has done none of that.

- CMS is making ad hoc and variable decisions about financing rules and waiver conditions.
- Waivers and even State plan amendments are being held hostage until States give up options that the statute says are State prerogatives.
    - For example, intergovernmental transfers (IGTs) and Targeted Case Management (TCM) are both provided for in Title 19—and while there may be abuses of them, the Administration has never defined what is abusive and what is not—much less made those definitions formal.
- States are being asked to agree to terms and conditions that people do not even understand.

- For example, the Administration is pressing for States to substitute certified public expenditures (CPEs) for intergovernmental transfers (IGTs), without any clear definition of what is allowed in the former or what was wrong with the latter. In informal discussions, I have found that even Federal auditors do not understand the new terms and what they do or do not include.

Good State Medicaid directors feel that they are being treated unfairly—and they are. Given the huge catch-up work that Medicaid has to do, they are looking for—and their Governors expect them to find—any way to stretch limited State dollars while staying within the law. They think that they are running their programs correctly, but the rules seem to change midstream. Sometimes they have to spend more time justifying what they did yesterday than doing what they need to do today or planning what they will do tomorrow.

This Committee has expressed serious concern that CMS is running Medicaid through waivers that are not transparent in their content or their process, leading to an uncertainty among advocates, States, and even lawmakers about what is allowed and what is not. In passing, I would say that your concern about waivers is even more pressing now: the Administration is taking over what should be Congress's job, and special terms and conditions are trumping Title 19. More and more frequently, the statute and some of its most fundamental promises are being waived away outside of the public view.

But my main point is that the manner in which CMS is administering State-financing rules is directly parallel to its treatment of waivers, and it should raise similar concern. Decisions worth billions to States, providers, and beneficiaries are being made in private, often as part of large, complex, and unreviewed deals. CMS methods and policies in this highly technical area are opaque, not transparent.

Most States do not want to find themselves on the wrong side of Federal auditors. But how can they be sure that they will not if the rules are unspoken and unwritten? Equally important, this basic uncertainty about financing makes it harder for State officials to do their real jobs—managing their programs to hold this strained safety net together.

This is not the way to run a program as complex and important as Medicaid. If the Administration has determined that a current financing system is illegal under current statute and regulations, the Administration should say that clearly and enforce the law evenly and fairly in all States. If they have determined that a practice is legal under the regulations but inappropriate, they should propose a change in the regulations; that's what I did—with GAO and OIG support. If they have determined that a practice is legal under the statute but inappropriate, they should bring the Congress a proposal to change the statute. No one is well served by this ad-hoc, non-transparent approach.

Let me also remind the Committee that running the program this way creates a high risk of increased Federal costs. If a State were to file and win a suit against CMS for acting in an arbitrary and capricious manner by failing to go through formal changes in the regulations, the State would be entitled to claim back payments all the way back to the beginning of the fiscal quarter in which it first filed its State plan amendment. The best protection against being found to be "arbitrary and capricious" is to go through the process for rulemaking laid out in the Administrative Procedures Act. Agencies that do so are given substantial deference by the courts. Agencies that fail to do so generally lose that deference. There are billions of dollars at stake here.

Going through transparent and formal process to clear up financial integrity issues is hard work. But it is necessary if the Federal government is to be a reasonable partner with States and if the Federal government is to protect Medicaid and the fisc from abuse.

Conclusion

I would be remiss if I did not refer you to the thoughtful work of my former deputy, Penny Thompson, who came to the Medicaid program from the OIG and the HCFA Office of Program Integrity. She has outlined a series of financial safeguards and management structures in her work, "*Medicaid's Federal State-Partnership: Alternatives for Improving Financial Integrity*," done for the Kaiser Commission on Medicaid and the Uninsured last year. Most of the measures she describes can be accomplished without legislative change, requiring only a CMS commitment to do so.

Finally, in closing, I would ask that the Committee not approach these issues as a means of cutting the Medicaid budget. Find all the waste, fraud, and abuse that you can. Provide a legislative means to stop it or press the Administration to use current law to do so.

But then plow those savings back into Medicaid. Give the States dollar-for-dollar relief of the estimated billion dollars of new costs of Medicare Part D and, thus, make both programs as successful as possible. Reduce the clawback. Stop the drop in FMAP in the 29 States that are about to be cut. Enact the Family Opportunity Act. These are important measures to protect Medicaid as the safety net under all the rest of American health care, and Medicaid needs all the help it can get.

Thank you.

Attending to Medicaid

Cindy Mann
Tim Westmoreland

> *[P]layers line up in a long line and hold hands. The player at the front of the line is the 'head' and the player at the end of the line is the 'tail'....The game begins when the head begins to run wildly in any direction, making sharp turns and quick double-backs....The force created by the twists and turns will often send the tail of the whip flying....It may be best for the tail to hold on with both hands to keep from flying off the end. Sometimes, however, the tail will go flying no matter how hard they hold on...Be prepared to get dirty if you play this game!*
>
> —"Crack the Whip," *Party Game Central*[1]

If the evolution of American health policy (in both its purposeful and its accidental forms) is compared to the children's game of Crack the Whip,[2] then there is no question that the Medicaid program is the tail of the line. When those at the head of the line (e.g., employer-based insurance, Medicare, managed care plans, and pharmaceutical companies) start to move, Medicaid receives whatever shocks and unintended consequences result, and when the line "begins to run wildly in any direction," it receives them faster and harder than the players at the center.

Shocks also come from other sources. When the economy slumps, an epidemic arises, or a path in another part of the system becomes a cul-de-sac, new twists and turns occur, with Medicaid absorbing much of the change.

Given all this activity and change, Medicaid has filled its various roles well. Medicaid works – not only for its original beneficiaries but also for almost every group, purpose, and problem with which it has been charged over the years. Despite some creaks and considerable stress, it has proven surprisingly resilient and even supple as the line has gone flying.

But as we discuss and plan the next round of health reform (be it tax-based, employer-based, or public; be it incremental or systemic), we should do so with Medicaid in mind. Medicaid deserves more attention and intention. Rather than leaving it as an afterthought at the tail, we should plan affirmatively for Medicaid improvements so that Medicaid is stronger and more able to absorb the shocks and do its job. To the extent possible, we should work to ensure that Medicaid fits the system and the system fits Medicaid. Doing so will improve the strength of the whole line and make it less likely that any part will fly off the end.

This paper is organized into three parts. The first is a discussion of the current role of Medicaid. The second is a brief description and history of the evolution of the program. Finally, the paper concludes with a discussion of Medicaid's likely role in a reformed system, and with proposals that address some of the tensions in the present system as well as the need to expand and simplify Medicaid in order to cover more of the uninsured. Each of these sections is necessarily brief, building upon more extensive writings by others.[3] Together, they underscore the extent to which Medicaid is intertwined with other parts of the health care system and how important it will be – not just for Medicaid, but for the entire system – to give Medicaid due consideration as system-wide reform moves forward.

The Current Role of Medicaid: Where Are We Now?

Medicaid is now the largest single insurer in the United States in terms of the number of beneficiaries enrolled and dollars spent. It

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covers more than fifty million people (while Medicare covers forty-one million),[4] and total (state and federal) expenditures are projected to reach $305 billion in 2004 (in contrast to $278 billion for Medicare).[5] Medicaid accounts for seventeen percent of all U.S. health expenditures.[6]

Medicaid is also the most heterogeneous insurance program in the country.

- Its beneficiaries are extraordinarily diverse: It is the largest insurer of children[7] and of people with disabilities,[8] and also includes a large number of elderly people.[9]
- Its services are also varied (reflecting the needs of its beneficiaries): It is the largest single provider of maternity care,[10] the largest single purchaser of prescription drugs,[11] and the largest financer of nursing home care.[12]
- Its institutional dependents are wide-ranging: By all reckonings, public hospitals[13] children's hospitals[14] community health centers,[15] and public clinics[16] depend on Medicaid to stay afloat.

Moreover, Medicaid has served as a stopgap for other public programs, picking up beneficiaries here, providing wrap-around benefits there, and filling in holes in other places. For example, the more prominent Medicare program has eligibility limitations (such as the twenty-nine month waiting period for people with disabilities and the minimum number of quarters of work requirement) that keep many disabled and elderly people from qualifying. In addition, those who are enrolled in Medicare have significant gaps in coverage (most notably long-term care and – at least until 2006 and perhaps beyond – prescription drugs). Similar observations might also be made about the limited availability and usefulness of other sources of coverage and health-related services (such as veterans' health benefits, the Ryan White program, the Maternal and Child Health Block Grant, and COBRA continuation benefits). In one way or another, Medicaid fills in some of the gaps in each of these programs.

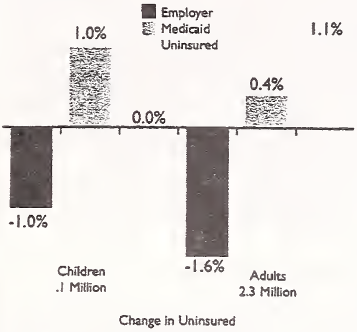
Medicaid is also the health policy tool that has proven most immediately responsive to social change and to newly recognized health and health-systems-delivery problems.[17] It responds in the event of both mass recessions and individual job losses, providing assistance for whole regions in economic downturn as well as to discrete families in transition.[18] It has proven to be the health-finance first-responder to public health problems and even disaster situations.[19]

Medicaid's strength for the populations it serves and the providers who serve them is its entitlement to affordable coverage for a broad range of services. The entitlement is a legal requirement that directs states, as a condition of receiving federal Medicaid funds, to enroll all eligible people who apply.[20] There are many facets of the entitlement – consequences that flow from the simple directive that all eligible people must be enrolled. Most notable, perhaps, is Medicaid's open-ended financing structure, which is tied closely to the entitlement. The longstanding arrangement under Medicaid is that in exchange for taking on the obligation to serve all eligible people, states are guaranteed funding for the federal share of all costs that flow from that obligation. If enrollment rises, so does federal financial participation. It is difficult to imagine how an entitlement program the size of Medicaid could be maintained by the states without the open-ended federal commitment of federal funds and, at the same time, it is difficult to imagine that the federal government would continue to provide open-ended financing to states if states were not obligated to serve all eligible people.

The entitlement also has the effect of keeping the program honest – it ensures coverage to all those who qualify by giving its intended beneficiaries the ability to enforce that promise and to guard against arbitrary (intentional or unintentional) delays or denials of coverage or services. In addition, the entitlement undergirds Medicaid's counter-cyclical role: Medicaid is the only source of health coverage that expands when the economy contracts. In its 2003 annual release of insurance data, the U.S. Census Bureau identified Medicaid as the major reason why many more people did not become uninsured during the 2001-2002 economic downturn.[21] In that year, Medicaid enrollment growth more than offset the sharp decline in employer-based coverage for children and partially offset those declines for adults. It was the entitlement nature of the program – the legal requirement for states to enroll all those who are eligible and who apply – that allowed (indeed required) the program to expand in response to greater need.

Figure 1

Changes in Health Insurance Coverage Rates, Children vs. Adults, 2001-2002 (Percentage Point Differences)



Source: "Health Insurance Coverage in America: 2002 Data Update." Kaiser Commission on Medicaid and the Uninsured, December 2003.

Uninsured people are not the only beneficiaries of the entitlement. Health care providers, particularly those who depend on Medicaid for a large share of their revenues, would suffer serious consequences if Medicaid payments for services could be turned on and off depending on how many people had enrolled that year or the cost of the services provided to those enrollees. No major health insurer – whether it operates in the public sector (like Medicaid and Medicare) or in the private sector – could function for long without providing a legal guarantee of coverage and payment for services.[22]

The Evolution of Medicaid: How Did We Get Here?

Altogether, Medicaid is now large, varied, vital, and remarkably adaptable. But this central role of Medicaid in the midst of health financing is largely a policy accident, and would probably be quite a surprise to its original authors. No one ever sat down to design a big, heterogeneous, responsive, "last-ditch" insurance program. Rather, the major health debates and changes have primarily focused on such high-profile programs and policies as Medicare, commercial insurance regulation, competition, and managed care, leaving Medicaid – sometimes by design and often by default – to take up the slack.

For example, the limitations of the coverage of nursing home services under Medicare (which generally pays for such care only after hospitalization and, then, only for a short time) led – not by design but largely by default – to Medicaid picking up much of this large and growing responsibility. Similarly, the narrowness and cost of COBRA continuation benefits, when combined with the lengthy waiting period for Medicare, have resulted in Medicaid becoming a primary payer for workers (and their families) who become disabled.[23] In these instances federal law was not affirmatively amended to have Medicaid take on these roles; Medicaid was a programmatic "Good Samaritan," providing assistance just because it was there. The list of programs and services that Medicaid has come to prop up is long and varied.

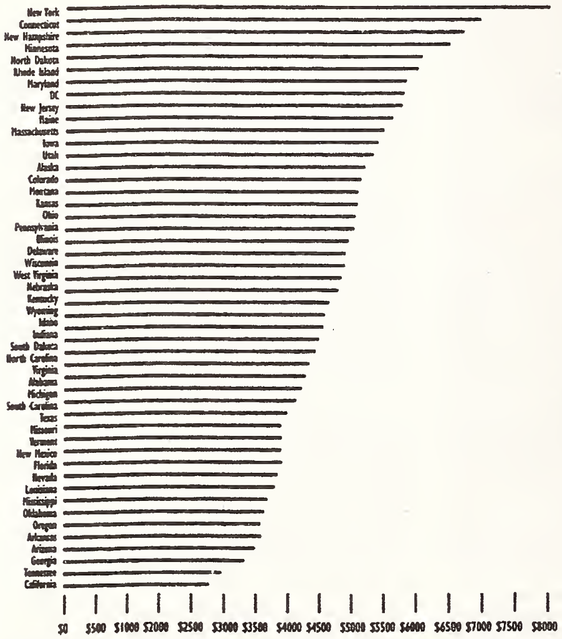
Medicaid is now large, varied, vital, and remarkably adaptable.

Even when Medicaid has been affirmatively addressed with legislation, its expansion has been geological, growing by accretion as layers of beneficiaries, benefits and providers dealt with poorly by other parts of the system have been added or assisted. Sometimes this has occurred through the adoption of new federal mandates but more often (and particularly recently) growth has occurred when states have taken advantage of new or longstanding program options.

From its inception in 1965, the program has been jointly funded and administered by the federal government and the states. The statute has balanced the federal interest in having some minimum national standards and accountability for the substantial amount of federal dollars spent with a recognition that states need flexibility to design their programs in light of local conditions and to have some control over costs. The balance struck sets minimum federal standards with respect to eligibility, benefits, and beneficiary costs, but allows states to decide whether to expand coverage and benefits beyond the statutory minimums. States also have broad discretion to design their service delivery systems and to set provider rates.

The extent of the discretion is evident from many perspectives. Nationwide, Medicaid covered forty percent of the low-income population who were not covered by private insurance (in 1998-2000), but the variation across states is considerable and due largely to state policy choices. Among the thirteen states studied through the Urban Institute's Assessing the New Federalism program, Medicaid penetration among the low-income uninsured ranged from a low of 27.9 percent in Colorado to a high of fifty-nine percent in Massachusetts.[24] Another indication of the flexibility within the program is the difference in levels of spending per beneficiary. In 2001, New York spent $7,749 per beneficiary compared to only $2,334 in California.[25] It is often said that if you have seen one state Medicaid program, you have seen one state Medicaid program.

Figure 2
Total Medicaid Expenditures per Beneficiary, FY 2001



Source: Georgetown Health Policy Institute analysis based on MSIS 2001 data. No data available for Hawaii or Washington State.

Medicaid's Geological Evolution

The Medicaid program began by focusing narrowly on people receiving welfare: children, their "caretaker relatives", and the "aged, blind, and disabled" – all persons deemed too vulnerable to provide insurance for themselves.[26] Beginning in 1984, the general requirement of a link between federal cash assistance and Medicaid began to wither away, although Medicaid still focused on people too poor to insure themselves.[27] Required coverage was extended to children and some pregnant women who met the welfare eligibility standards (but who might not actually be receiving it). In 1986, an option was created for states to enlarge voluntarily their coverage to include all pregnant women and infants below the poverty level (regardless of their receipt of welfare)[28] and, by 1988, such coverage was required.[29] Likewise, in 1986, states were allowed to include some low-income people on Medicare (the so-called "Qualified Medicare Beneficiaries," or QMBs) to pay for the out-of-pocket costs imposed by Medicare,[30] and in 1988 such coverage was required.[31] The next year, minimum eligibility was expanded to include pregnant women and young children up to 133 percent of poverty.[32] In 1990, the gradual phase-in of coverage for poor children up to age eighteen was begun (completed recently in 2002), and another group of low-income people on Medicare (the "Specified Low-Income Medicare Beneficiaries," or SLMBs) was added and given some help with Medicare cost-sharing.[33]

By 1996, with the repeal of the federal welfare program for children and their families, Aid to Families With Dependent Children (AFDC), the link between cash assistance for poor families and Medicaid was broken entirely (although the old AFDC income thresholds were retained as the federal floor on eligibility). Family coverage must now be provided regardless of eligibility for welfare, although the minimum income eligibility standards for parents remain quite low.[34]

In all cases where coverage is required under Medicaid (i.e., for infants, pregnant women, older children, parents, the elderly, and people with disabilities), states have the option to expand their program to cover people in these groups at higher income levels. Most have done so to some degree for some groups of beneficiaries.

In 1997, the State Child Health Insurance Program (SCHIP) was created, giving states even more options with respect to children's coverage. SCHIP encourages states (through higher federal matching payments) to provide insurance for children whose family income is higher than pre-SCHIP state Medicaid levels.[35] At state option, SCHIP funds can be used to finance a stand-alone, non-Medicaid program or to expand Medicaid.

In a different vein of policy development, recent moves have been made to use Medicaid for coverage of people with disabilities who are not, by any routine standard, low-income but who are, nonetheless, effectively priced out of the private market because of its targeted risk underwriting for all but the largest group insurance plans. In 1997, states were allowed to include working people with disabilities with income up to 250% of poverty[36] and, in 1999, even that limit was removed.[37] Most recently, legislation has come near passage to make a similar provision for children with disabilities who are part of non-poor families.[38]

> In hindsight, one could have predicted that Medicaid would become central in health financing. Other public and private programs are intended for "average people," i.e., people with "average income" generally sufficient to pay for health insurance and people with "average health care needs."

Parallel to these incremental expansions of eligibility were gradual legislative extensions of assistance to certain providers of services to low-income people. In 1981, states were required to make special payments to Disproportionate Share Hospitals (DSH).[39] In 1989 guarantees of Medicaid coverage and payment floors for community health centers and other poverty clinics, the Federally Qualified Health Centers (FQHCs), were enacted.[40]

Beyond this gradual broadening, Medicaid has also been enlarged through legislation to ensure that children received the scope of coverage they needed. In 1989, the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit (which was originally established in 1967) was strengthened. Medicaid law now guarantees children coverage for regular health visits and dental, hearing, and vision screenings, as well as for any treatment found to be medically necessary.

Congress and the states have also regularly turned to Medicaid as an ad hoc response to certain health problems. In 1993, after tuberculosis outbreaks occurred in the late 1980s, states were allowed to extend eligibility for Medicaid to people who test positive for TB.[41] Also, in an effort to increase pediatric immunization rates, Medicaid was expanded to pay for vaccine for uninsured and underinsured children who are not themselves Medicaid beneficiaries.[42] In 2000, states were allowed to open eligibility to uninsured women who are diagnosed with breast or cervical cancer in a screening program supported by the Centers for Disease Control and Prevention.[43]

Progress and Tension

And Medicaid has worked. All states have implemented the program, many have taken advantage of program options, and enrollment has increased dramatically for all groups of people.[44] The breadth of benefits available for children with disabilities is far more medically appropriate than any other insurance package.[45] Cost-sharing generally has been held to a level that does not impede access by low-income people. And, most important, study after study has shown that people covered by Medicaid have better access to care and better health outcomes than people without insurance.[46] Observing it at a distance, far enough from the daily cracks of the whip, shows that, even as the perennial tail of the health policy process, Medicaid has held on and made remarkable contributions.

This is not to say that Medicaid's growth and development has always been easy. While Medicaid's unique brand of federalism has helped keep the program in balance and lend it the flexibility to evolve, it has also been a breeding ground for tensions. These tensions have sometimes compromised Medicaid's ability to do its job and have, on occasion, pushed the program into crisis. The tugs and pulls play out on two different levels: between and among states, local government, providers and beneficiaries ("To serve or not to serve"); and between states and the federal government ("Your money, my rules").

To Serve or Not to Serve

States are responsible for twenty-three to fifty percent of Medicaid benefit costs.[47] Any new person covered, any new outbreak of disease, and any new medical advance achieved will affect a state's bottom line. As Medicaid has grown, so has its influence on state budgets. Nationwide, Medicaid accounts for about sixteen percent of state general-fund spending, second only to education.[48] Whatever its benefits may be to states, Medicaid represents a significant financial undertaking for them.

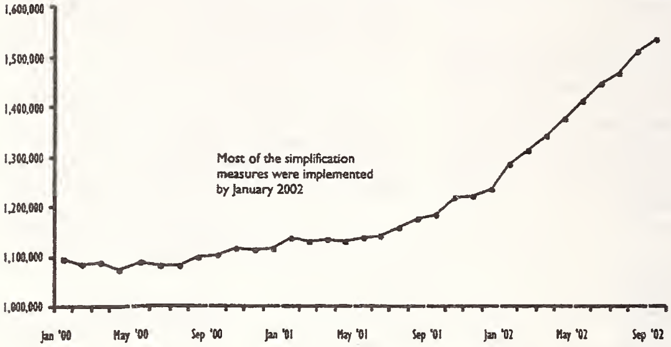
The tensions created by state budget pressures play out in a number of ways. Over the years, the lack of outreach, as well as complicated and sometimes stigmatizing application and renewal procedures, have dampened participation (and damaged the reputation of the program).[49] These practices have their roots in the program's historic ties to welfare, but states have long had the flexibility under federal law to simplify the process. Many chose not to do so, largely due to the costs associated with more robust participation. And, of course, states were right about the relationship between barriers, participation rates, and costs. When states simplified enrollment procedures for children in Medicaid after the enactment of SCHIP made covering children a valued goal, enrollment – and costs – rose.[50] In the wake of state budget shortfalls, several states have rolled back their simplification measures.[51]

Low provider payment rates have also been used to keep Medicaid costs down. Lower-than-market rates generally contribute to Medicaid's ability to deliver services at a lower cost than private insurance.[52] While, in most cases, people still have access to care at levels comparable to private insurance,[53] in some places at some times, low rates have compromised Medicaid's ability to assure access to care.[54] This is a problem: The entitlement is little more than a hollow promise if providers are not willing to serve.

Budget constraints also deter some eligibility and benefit improvements. Another remnant of Medicaid's historic ties with welfare is that there is no eligibility category for childless adults.[55] This group of people cannot be covered under Medicaid (without a waiver), no matter how poor they may be. In large part, this problem has not been fixed because of the reluctance on the part of states and the federal government to assume the cost of extending coverage.

Similarly, the lack of community-based long-term care services funded by Medicaid is a consequence of funding pressures and priorities. Medicaid law requires states to offer nursing home services

Figure 3
Texas Child Medicaid Enrollment Before and After Simplification Monthly average, January 2000 to September 2002



to eligible beneficiaries, but home- and community-based long-term care services are not required. This imbalance between institutional and community-based services is not an oversight. It is a reflection that states believe they cannot afford the costs if these services were opened up to all who qualify.[56]

My Rules, Your Money

Some of the tensions in the program play out mainly between the states and the federal government. As noted above, both levels of government share responsibility for program costs and program rules.

Even though about two-thirds of all spending under the Medicaid program is optional (either for optional services for mandatory beneficiaries or for all services provided to optional beneficiaries),[57] not surprisingly – and, from their perspective, understandably – states would like more authority over program rules. During the past decade, the program has moved in this direction,[58] although the principle that Medicaid should operate according to minimum federal standards in the areas of eligibility, benefits and beneficiary costs has remained intact, at least as a matter of federal law. The Bush Administration's aggressive promotion of waivers, however, has put many of these basic statutory standards in question through the section 1115 waiver process.[59]

The tugs and pulls between the states and the federal government over financing have been even more intense. Medicaid's financing structure is designed to assure that federal funds increase when costs rise and to encourage states to take advantage of options to improve coverage. States (understandably) work the system, looking for ways within the rules to maximize their federal payments. At times, states have taken these measures to extremes and, in effect, distorted the statutorily established matching rate.[60] Some have found ways to use federal Medicaid dollars to fund other state priorities or reduce state taxes. When this happens, the federal government typically takes steps to close down the practice, although not always completely or in an even-handed or transparent way.[61] During the early 1990s and again in 1999 and 2000, the struggle between states and the federal government over whether and to what extent certain financing mechanisms would be permitted dominated Medicaid debates.

These tensions become all the more acute when Medicaid costs are rising relative to available state revenues. This is one of those times. As a result of state budget pressures, states are cutting optional coverage and benefits, eliminating many of the simplification measures that had been adopted to promote participation, and freezing or reducing provider payment rates in ways that could jeopardize access to care.[62] Some states have also secured a "waiver" of federal minimum standards, permitting them to cap enrollment (i.e., end the entitlement), increase beneficiary costs, and eliminate coverage for mandatory services (such as hospital care).[63]

The Bush administration has generally welcomed a shift in the paradigm towards fewer federal programmatic standards,[64] but it has taken the opposite approach on fiscal matters. In 2003, the Administration proposed legislative changes that would cap federal Medicaid payments to states and, in 2004, it proposed to close down financing mechanisms it believes are abusive (including some that it re-opened the door to in the past).[65] Even without new legislation, HHS is engaging in new levels of fiscal review,[66] adding to state fiscal woes and the acrimony between state and federal administrators.

So far, the Congress has largely stayed out of the recent skirmishes, although it did recently take action having a significant fiscal impact. Legislation adopted in 2003 temporarily shifted some state Medicaid costs to the federal government through an 18-month increase in the federal Medicaid matching rate.[67] The matching rate change helped states avert eligibility rollbacks and other reductions in coverage and benefits.[68] Fiscal relief has not been sufficient, however, to forestall significant retrenchments.[69] Continuing budget pressures have prompted many states to take action or to consider taking action that will have large, negative long-term consequences on the program's ability to fulfill its mission.[70]

Medicaid is always under some stress. But some have identified this period in the life of the program – a time of weak state revenue growth, rising health costs, and demographic shifts – as "the perfect storm."

The Future of Medicaid: Where Should We Go From Here?

In hindsight, one could have predicted that Medicaid would become central in health financing. Other public and private programs are intended for "average people," i.e., people with "average income" generally sufficient to pay for health insurance and people with "average health care needs." Private sector insurance is not designed for people who cannot afford to pay premiums or for people with a predictable need for chronic care. If there was to be coverage for these people and payment to their providers, then some other mechanism for providing coverage and financing had to be invented. Without Medicaid, some people would not receive the care they need and, to the extent that they did receive care, then states, localities, providers, and (through cost-shifting) other payers would be stuck with the bill.

Recognizing the need for a program like Medicaid, most health care reform proposals contemplate some combination of public programs and private coverage.[71] As long as the nation continues to rely primarily on private insurance, it is difficult to imagine how the system could function effectively without Medicaid.

A reformed system will continue to need Medicaid to occupy a central role for four main reasons. First, Medicaid will be needed to provide coverage to those priced out of private insurance. The breadth of this group will depend on the extent and nature of other reforms and whether reform is intended to ensure universal coverage. Currently, a high portion of low-wage workers are uninsured either because they are not offered work-place coverage or their employer's contribution toward the cost of the premium is too low to make the product affordable.[72] Some reform proposals would require employers to offer coverage or to contribute toward the cost of coverage. Others would offer tax credits to help low-income people purchase private insurance. The level of financial support available, either through an employer or a public subsidy, and the structure of that subsidy will affect the scope of Medicaid's role insuring low-wage workers and their families. It seems unlikely (in part for the reasons discussed below) that any new approach could be sufficient to reach all low-income people at its outset.

> We can continue to shortchange Medicaid and its beneficiaries, react to the crisis of the moment, and let the key elements of the program unravel under multiple points of pressure; or we can take advantage of the interest in system-wide reform and take the steps necessary to help Medicaid achieve its objectives well.

Second, by taking responsibility for many of the people eschewed by private insurance no matter what their ability to pay, Medicaid essentially functions as a high-risk pool. Without significant insurance reforms, Medicaid will still be needed to provide coverage to people with chronic illnesses and disabilities.

A third reason for continuing Medicaid under a reformed system is that Medicaid generally serves the people left out of private insurance – whether due to price or medical condition – better than private insurance. A publicly-funded coverage program is uniquely suited to provide full financial support (i.e., with no or very limited premiums, no deductibles, and only nominal cost-sharing) for a broad array of benefits to people with little or no means to purchase those benefits on their own; to respond promptly to changes in families' financial needs and circumstances; and to help those who fall between the cracks due to frequent job transitions, immigration status, and other factors.[73] And it does all this at a relatively low cost.[74]

Finally, Medicaid's role as a major financer of the system cannot be ignored. In 2004, Medicaid pumped over $300 billion into the health care system. Nearly half (43 percent) of that amount comes from states and would be hard to capture and redirect in a reformed system.[75] The absence of these funds would leave a gaping financing hole not just for so-called safety-net institutions but also for many providers with a mixed-payer base.

Medicaid's role will vary and adjust depending on the extent of the broader reforms that might be adopted, but inevitably there will be a need for an efficient, publicly funded partner for coverage and financing. With apologies to Voltaire,[76] if Medicaid did not exist, it would be necessary to invent it. The program, however, is under considerable stress, in part because it has grown to meet myriad needs without the benefit of system-wide planning.

Whatever the design of comprehensive system reform may be, it should be made with Medicaid's unique mission in mind and, moreover, in concert with a number of changes to Medicaid itself. While the "crack the whip" approach does not do justice to Medicaid or its mission, neither does an approach to reform that focuses exclusively on the current tensions in the program and that ignores Medicaid's relationship with other parts of the system and the need for broader system-wide reform, and, most fundamentally, the need to reach many more of the currently uninsured. With this caveat in mind, four areas for potential Medicaid reforms are discussed below.

Financing

First and foremost, Medicaid needs a financing method that provides a reliable and adequate source of funds that can adapt to changing needs or rising costs without sending the program (and its beneficiaries and providers) into crisis.[77] Maintenance of open-ended federal financing is, therefore, critical. Moreover, the mismatch between health care costs and state financing capacity, the important national interests underlying the program, and the aging population point to the need for even greater federal financial responsibility. This could be accomplished by shifting a greater share of the cost of the program onto the federal government, for example, through a higher across-the-board matching rate. Alternatively (or in addition), certain policies could be adopted that would increase the federal government's fiscal responsibility in more specific ways. Two changes deserve particular attention.

Federal Medicaid matching rates should adjust automatically so that the federal government assumes a larger share of costs during an economic downturn. Medicaid's entitlement prompts the program to do more when the economy sours, but states' capacity to absorb added costs in these times is limited. Because of its broader tax authority and its abilities to borrow, the federal government is in a better position to take on these costs and to ensure that Medicaid coverage remains intact when it is needed most.

The federal government also should assume more responsibility for the impact of the aging population and the burgeoning cost of serving people who are receiving both Medicare and Medicaid. Medicaid's responsibility for these individuals has been growing steadily over the years.[78] In 2001, their costs accounted for more than forty percent of all Medicaid spending.[79] Among the many concerns regarding Medicaid's responsibilities for Medicare beneficiaries, perhaps the most significant are the growing cost of long-term care and the lack of community-based long-term care services. While Medicaid has become the principle financer of long-term care, state revenue systems are ill-equipped to handle this large and growing responsibility or to assume a major role in financing the modernization of the long-term care benefit. With the aging of the baby boomers and the contraction of private retiree coverage, cost pressures will become more extreme.

Eligibility Rules and the Systems for Accessing Coverage

A national income eligibility floor now exists for children; however, minimum income standards for children still vary by age, and much lower eligibility standards for their parents leave many families with only partial coverage.[80] Eligibility "cliffs" also exist, for example when a child becomes an adult and after a pregnant woman gives birth, often leading to the loss of coverage. And, as discussed above, childless adults are not eligible at any income level (without a waiver).

Arcane and inequitable eligibility categories and income standards ought to be replaced with a national minimum income floor for all people based on their ability to purchase insurance that addresses their medical needs. How high these income standards should be and the pace of implementation will depend in part on other reforms that might be undertaken and the amount of resources that will be devoted to reform.

More uniform minimum eligibility standards should be coupled with measures that would simplify program administration and boost participation rates. Approaches could be adopted that make signing up for coverage easier and more automatic (as it is for employer-based coverage). People should be able to apply by mail, by phone and online, and at a variety of sites. (This is the practice now for some groups of people in some states). Another promising approach is linking enrollment to other programs and services. People could sign up for coverage when they pay their taxes, enroll their child in school, or when a member of the family applies for Social Security, or unemployment insurance benefits. Enrollment could be stabilized and costly churning[81] reduced through more streamlined renewal systems and measures, such as "continuous eligibility," that prevent minor fluctuations in income from resulting in coverage gaps. In short, mechanisms that make it difficult for eligible families to enroll and stay enrolled should be dropped.[82]

Linkage with the Employer-Based System

As Medicaid has expanded to cover more families and individuals with ties to the workplace, systems are needed to help smooth the transition between private and public insurance (in both directions). A number of changes could help, but first, the ambivalence about public programs reaching out to cover low-wage workers and their families needs to be resolved. Concerns about public coverage programs "crowding out" or replacing employer-based coverage have kept policies muddied at best and counterproductive at worst. (For example, one commonly-used policy to prevent crowd out requires that a person remain uninsured for a period of time before qualifying for public coverage.)

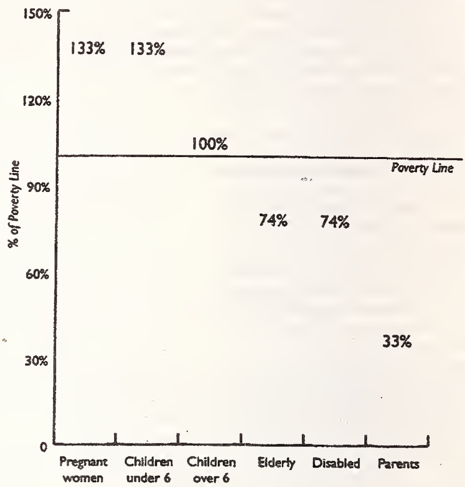
Publicly funded coverage can do a better job filling this gap if coverage policies are encouraged in a more considered and consistent way. For example, states would be more likely to extend coverage to low-wage earners if they were permitted to pool state resources with those of employers. One way to do this is to allow states to treat employer contributions toward the cost of coverage as part of a state's payments that could be matched with federal funds. To the extent that Medicaid reached up the income ladder and covered families with somewhat higher incomes, modest premiums and cost sharing might be permitted as well.[83]

In another vein, to the extent that the tax system is used to promote coverage among more moderate-income households, it might be appropriate to consider aligning the methodology to calculate any tax-based relief with the methodology to calculate Medicaid financial eligibility (for example, by using adjusted gross income in both contexts). The current system is a crazy quilt in terms of the treatment of income and assets. Alignment would facilitate transitions between programs for providing financial support for coverage.

Additionally, disruptions in care that arise when people move in and out of Medicaid could be avoided if private insurance and public programs relied on many of the same health plans and providers. Plans and providers might be required to participate in Medicaid in order to operate in the state or as a condition of contracting with the state or a local unit of government. (For example, plans that sign up to offer coverage to state employees and retirees could be required to also open their doors to Medicaid beneficiaries).

Figure 4

Minimum Income Eligibility Standards for Medicaid by "Eligibility Group"



Note: The income level for parents varies by state; 33% is the mandatory minimum income level for a family with no earnings in the median state, relative to the 2004 federal poverty line. Families with earnings in some states are eligible at modestly higher income levels due to "earnings disregards."

Waivers

Last but far from least, there are waivers. Over the past few years, the Administration has actively encouraged states to restructure their programs through broad-based "section 1115" waivers.[84] These waivers allow states to use federal Medicaid and SCHIP funds in ways that do not conform to federal law. Waivers can help states expand coverage or they can give states new ways to restrict coverage. Either way, they have resulted in significant programmatic and financing changes without open debate or much deliberation.

Waivers were originally intended to promote discrete "research and demonstration" projects, but they have long since lost that characterization. Little research or study is expected or conducted, and "copy-cat" waivers are common. In addition, waivers offer states only a limited ability to expand coverage and can push states into compromising financing arrangements (i.e., per-person or, in some cases, global caps on federal payments) because of a longstanding federal policy (not required in statute) that waivers be "budget neutral" to the federal government.[85]

Waivers should not become a substitute for rulemaking or a way to circumvent the law.[86] If the statutory or regulatory provisions that govern the program are out of date or inappropriate, they should be debated and changed. Far too many people and far too much money are at stake for these decisions to be delegated to back-room negotiations. On the other hand, waivers that are truly of a research and experimental nature and that promote the objectives of the program have a value, if conducted within clear bounds and with study and analysis. In fact, federal funds should be available for such efforts as a way to promote new ways to deliver services, measure quality, promote participation, and contain costs without compromising care.

Conclusion

Medicaid's ability to operate effectively and efficiently is notable given how much it has been asked to do. Like almost all aspects of the American health care system, however, the program is at a crossroads and is likely to change. There is a choice on how to proceed: we can continue to shortchange Medicaid and its beneficiaries, react to the crisis of the moment, and let the key elements of the program unravel under multiple points of pressure; or we can take advantage of the interest in system-wide reform and take the steps necessary to help Medicaid achieve its objectives well. If we make the system fit Medicaid and Medicaid fit the system, we can transform the evolution of American health policy from Crack the Whip to a team sport.

Acknowledgements

The authors would like to thank Theresa Jordan, Fouad Pervez, and Greg Reisher for their assistance.

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20. There is no single provision in federal law that concisely sets forth the entitlement to coverage. Judicial interpretations of the federal Medicaid law have generally grounded the entitlement in section 1902(a) (8), Title XIX of the Social Security Act, 42 USC.1396(a)(8).
21. *Health Insurance Coverage in the United States: 2002, supra* note 18.
22. By contrast, smaller public coverage programs (for example, separate, non-Medicaid, SCHIP programs) and other public programs that help pay for medical services (such as the Ryan White program, the Maternal and Child Health block grant program, and various pharmacy benefit programs) do not extend a legal entitlement to coverage. B. Smith and S. Rosenbaum, *State SCHIP Design and the Right to Coverage*, Center for Health Services Research (Washington, D.C.: George Washington University, 2001). As a result, the number of people provided services under these programs can be capped, waiting lists can be formed, and enrollment can be closed for budget or other reasons.
23. S. Dale and J. Verdier, "Issue Brief: Elimination of Medicare's Waiting Period for Seriously Disabled Adults," *Commonwealth Fund* 660 (2003), *available at* <http://www.cmwf.org/programs/medfutur/dale_waitingperiod_ib_660.pdf>(last visited July 1, 2004).
24. J. Holahan, *Variations Among States in Health Insurance Coverage and Medical Expenditures: How Much is Too Much* (June 2002), Urban Institute, *at* <http://www.urban.org/url.cfm?ID=310520> (last visited July 1, 2004) [Low-income is defined as having income below 200 percent of the federal poverty line].
25. Authors' analysis of MSIS 2001 data submitted by states to the Centers for Medicare and Medicaid Services. Data do not include Washington or Hawaii, neither of which have submitted data to CMS as of April 19, 2004.
26. Social Security Amendments of 1965, Pub. L. 89-97, 79 Stat. 286 (July 30, 1965) (codified as amended in scattered sections of 42 U.S.C.).
27. Deficit Reduction Act of 1984, Pub. L. 98-369, 98 Stat. 494 (July 18, 1984) (codified as amended in scattered sections of 42 U.S.C.).
28. Omnibus Budget Reconciliation Act of 1986, Pub. L. 99-509, 100 Stat. 1874 (Oct. 21, 1986), 42 U.S.C. § 1396a (2004) [hereinafter OBRA 1986].
29. Medicare Catastrophic Coverage Act of 1988, Pub. L. 100-360, 102 Stat. 683 (July 1, 1988), 42 U.S.C. § 1396a (2004) [hereinafter MCCA 1988].
30. OBRA 1986, *supra* note 28, 42 U.S.C. § 1396a, 1396d.
31. MCCA 1988, *supra* note 29, 42 U.S.C. § 1396d(p).
32. Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239, 103 Stat. 2106 (Dec. 19, 1989), 42 U.S.C. § 1395 et. seq. (2004) [hereinafter OBRA 1989].
33. Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, 104 Stat. 1388 (Nov. 5, 1990), 42 U.S.C. § 1396a (2004).
34. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104-193, 110 Stat. 2105, Aug. 22, 1996), 42 U.S.C. § 602 (2004).
35. Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 251 (Aug. 5, 1997), 42 U.S.C. § 1397aa (2004) [hereinafter BBA 1997].
36. *Id.*
37. Ticket to Work and Work Incentives Improvement Act of 1999, Pub. L. 106-170, 113 Stat. 1860, (Dec. 17, 1999), 42 U.S.C. § 1396o.
38. S. Rep. No. 265, 107th Cong., (2002), *at* <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107_cong_reports&docid=f:sr265.107.pdf>(last visited July 1, 2004).
39. Omnibus Budget Reconciliation Act of 1981, Pub. L. 97-35, 92 Stat. 357 (Aug. 13, 1981), 42 U.S.C. § 1396uu (2004).
40. OBRA 1989, *supra* note 32, at 42 U.S.C. § 1396a (2004).
41. Omnibus Budget Reconciliation Act of 1993, Pub. L. 103-66, 107 Stat. 312, (Aug. 10, 1993), 42 U.S.C. § 1396a(a)(10)(A)(ii) (2004) [hereinafter OBRA 1993].
42. *Id.*, at 42 U.S.C. § 1396v.
43. Breast and Cervical Cancer Treatment and Prevention Act of 2000, Pub. L. 106-354, 113 Stat. 1381 (Oct. 24, 2000), 42 U.S.C. § 1396r-1b.
44. For example, federal program data show that there were 13 million beneficiaries in 1968; program data for 2001 show enrollment above 47 million.

The Congressional Budget Office projects that enrollment will reach 52.4 million in 2004. Health Care Financing Administration (HCFA) data for 1968 provided by the Kaiser Commission on Medicaid and the Uninsured; 2001 data from Georgetown University Health Policy Institute's analysis of the 2001 Medicaid Statistical Information System (MSIS) data; 2004 data from Congressional Budget Office's March 2004 Medicaid Baseline.

45. Crowley and Elias, *supra* note 8.
46. See, e.g. Key Facts: Children's Health - Why Health Insurance Matters (May 2002), Kaiser Commission on Medicaid and the Uninsured Website, *at* <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14132>(last visited July 1, 2004); see generally, *Consequences of Uninsurance*, Institute of Medicine Website, *at* <http://www.iom. edu/project.asp?id=4660> (last visited June 23, 2004).
47. This is based on the "regular" matching rates in effect in fiscal year 2004. Enhanced rates, which ended as of June 30, 2004, lowered state contributions to twenty to forty-seven percent. The federal matching rate varies by state, with poorer states having a lower state spending requirement. See, *Federal Medical Assistance Percentages*, United States Department of Health and Human Service Website, *at* <http://aspe.os.dhhs.gov/health/fmap.htm> (last visited June 23, 2004).
48. National Association of State Budget Officers (NASBO), *2002 State Expenditure Report* (Washington, D.C.: NASBO, 2003).
49. D. Cohen-Ross and L. Cox, "Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2000); General Accounting Office (GAO), *Medicare Savings Programs: Results of Social Security Administration's 2002 Outreach to Low-Income Beneficiaries*, GAO-04-363, March 26, 2004; M. Perry, S. Kannel, R. Valdez and C. Chang, "Medicaid and Children: Overcoming Barriers to Enrollment," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2000); GAO, *Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits*, GAO/HEHS-00-86, April 2000; V. Smith, E. Ellis and C. Chang, "Eliminating the Medicaid Asset Test for Families: A Review of State Experiences," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2001); GAO, *Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies*, GAO/HEHS-98-93, March 1998; P. Cunningham, "Targeting Communities With High Rates of Uninsured Children," *Health Affairs* Web Exclusive (July 25, 2001), *at* <http://content.healthaffairs.org/cgi/content/full/hlthaff.w1.20v1/DC1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=Targeting+Communities&andorexactfulltext=and&searchid=1088433853632_786&stored_search=&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff>(last visited July 1, 2004); G. Kenney, J. Haley and L. Dubay, "How Familiar Are Low-Income Parents with Medicaid and SCHIP?" *New Federalism Series* B. No.B-34 (Washington, D.C.: Urban Institute, 2001); L. Summer, S. Parrot and C. Mann, *Millions of Uninsured and Underinsured Children are Eligible for Medicaid* (Washington, D.C.: Center on Budget and Policy Priorities, 1997).
50. A. Dunkelberg, "Simplified Eligibility for Children's Medicaid in Texas: A Status Report at Nine Months," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2003); C. Mann, et. al., "Reaching Uninsured Children Through Medicaid: If You Build it Right, They Will Come," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2002).
51. V. Smith, et. al., "States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2004); National Conference of State Legislators (NCSL), *State Medicaid Actions: A Two-Year Review of State Actions as a Result of the States' Fiscal Crisis* (Washington, D.C.: NCSL 2003); L. Ku and S. Nimalendran, *Losing Out: States are Cutting 1.2 to 1.6 Million Low-Income People from Medicaid, SCHIP and Other State Health Insurance Programs*, (Washington, D.C.: Center on Budget and Policy Priorities, 2003).
52. J. Hadley and J. Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40, no. 4 (2003/2004): 323–342.
53. See *Challenges Facing the Medicaid Program in the 21st Century: Hearing Before the Subcommittee on Health of the House Committee on Energy and Commerce*, 108th Cong., October 8, 2003 (statement by Diane Rowland, Executive Director of the Kaiser Commission on Medicaid and the Uninsured).
54. GAO, *Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care*, GAO-01-883, September 2001; The problem has been particularly severe with respect to dental services, prompting the agency that oversees the Medicaid at the federal level (the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration) to issue a directive to states to take steps to examine whether low provider rates might be affecting children's ability to obtain Medicaid-financed dental services; see Letter from T. Westmoreland, Director, to State Medicaid Directors (January 18, 2001), *at* <http://www.cms. hhs. gov/states/letters/smd118a1.pdf> (last visited July 1, 2004).
55. As discussed above, originally, Medicaid eligibility was linked to welfare eligibility and childless adults did not fit under either of the two major welfare programs – the Aid to Families with Dependent Children program and the Aid to Aged, Blind and Disabled program (the precursor to the federal Supplemental Security Income, or SSI, program). Under the law, states can cover adults who are pregnant, living with a child, elderly or disabled.
56. This imbalance is mirrored at the Federal level in the consideration of legislation to require States to offer home- and community-based care. The Medicaid Community-based Attendant Services and Support Act (MiCASSA) has been introduced and re-introduced in the Congress for many years, but its consideration has been haunted by cost-estimates that are predicated on an assumption that more people would use such care than use institutional services. See R. Glazier, "The Re-invention of Personal Assistance Services," *Disability Studies Quarterly* 21, no. 2 (2001), *available at* <http://63.240.118.142/_articles_html/2001/Spring/dsq_2001_Spring_12.html> (last visited July 1, 2004).
57. Based on data analyzed by J. Holahan and B. Bruen, "Policy Brief, Medicaid Mandatory and Optional Eligibility and Benefits," *The Urban Institute* and *the Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2001).
58. For example, in 1997, federal law was amended to provide states more authority to set rates for institutional providers (nursing homes and hospitals) and to require Medicaid beneficiaries, under certain conditions, to enroll in managed care. In that same year, states were allowed new options to presumptively enroll children in Medicaid and to keep children enrolled for up to twelve months regardless of changes in financial circumstances; See Yellowbook, *supra* note 3.
59. Since August 2002, the Bush Administration has released three major waiver initiatives: the Health Insurance Flexibility and Accountability (HIFA) initiative, see, Centers for Medicaid and Medicare Services Website, *at* <http://www.cms.hhs.gov/hifa/> (last visited June 24, 2004); Pharmacy Plus, *at* <http://www.cms.hhs.gov/medicaid/1115/pharmacyplus.asp> (last visited June 24, 2004); and Independent Plus, *at* <http://www.cms. hhs.gov/independenceplus/> (last visited June 24, 2004). Each encourages states to submit section 1115 demonstration waiver requests that meet the guidelines set forth in these initiatives. The Administration has consistently cited waivers as a key policy tool to provide states greater programmatic flexibility; See, U.S. Department of Health and Human Services, News Releases, *Statement By Tommy G. Thompson, Secretary of Health And Human Services Regarding "Insuring America's Health" Report* (January 14, 2004), *at* <http://www.hhs.gov/news/press/2004pres/20040114.html> and *HHS Secretary Urges Congress To Approve Uninsured Package* (September 30, 2003), *at* <http://www.hhs.gov/news/press/2003pres/ 20030930b. html>(last visited July 1, 2004).
60. D. Rousseau and A. Schneider, "Current Issues in Medicaid Financing- An Overview of IGTs, UPLs, and DSH," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2004); GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes is Needed*, GAO-04-228, February 2004; T. Coughlin, et. al., "States' Use of Medicaid UPL and DSH Financing Mechanisms," *Health Affairs* 23, no. 2 (2004): XX-XX; GAO, *Major Management Challenges and Program Risks: Department of Health and Human Services*, GAO-03-101, January, 2003; GAO, *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*, GAO/HEHS-94-133, August 1, 1994.
61. See *Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes: Testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives*, 108th Cong. Committee on Energy and Commerce, March 18, 2004 (statement by Kathryn G. Allen, Director, HealthCare, General Accounting Office): 10; GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, GAO-04-228, February 13, 2004; GAO, *Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes*, GAO-02-147, October 30, 2001.
62. V. Smith, et. al., *supra* note 51; NCSL, *supra* note 51; Ku and Nimalendran, *supra* note 51.
63. S. Gill, J. Guyer, C. Mann, "Section 1115 Medicaid and SCHIP Waivers: Policy Implications of Recent Activities," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2000); For state-specific waiver fact sheets, see <http://www.kff.org/medicaid/waivers-index.cfm> (last visited June 24, 2004).
64. See discussion of waivers and waiver initiatives, *supra* note 59.
65. *Budget of the United States Government, Fiscal Year 2005: Department of Health and Human Services*, Office of Management and Budget (OMB) Website, Executive Office of the President Website, *at* <http:www.whitehouse.gov/omb/budget/fy2005/hhs.html> (last visited June 24, 2004).
66. See *Inter-governmental Transfers: Violations of the Federal-State Medicaid Partnership or Legitimate State Budget Tool?* Hearing Before the Subcommittee on Health of the House Committee on Energy and Commerce," 108th Cong., April 1, 2004 (statement by Dennis Smith, Director, CMS, Center for Medicaid and State Operations).

67. Title IV, Jobs and Growth Tax Relief Reconciliation Act of 2003. Pub. L. 108-27.
68. V. Smith, et. al., *supra* note 51.
69. T. Boyd and V. Wachino, "Is the State Fiscal Crisis Over? A 2004 State Budget Update," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2004).
70. For example, Oregon, has adopted a series of very deep reductions in coverage; it eliminated the portion of its program that covered people impoverished by their medical expenses and instituted new premium policies for poor adults that have caused about half of those adults to drop out of the program, See Oregon Health Research & Evaluation Collaborative Website, *at* <http://www.ohpr.state.or.us/OHREC%20welcome2.htm> (last visited June 24, 2004). Several states, including Florida and California, are considering major waiver initiatives that could affect the entitlement, benefits, cost-sharing and financing for everyone covered under their Medicaid programs. A. Ulferts "Bush Strives to Rein in Medicaid," *St. Petersburg Times*, February 22, 2004; A. Ulferts, "Medicaid Records Hard to Come By," *St. Petersburg Times*, March 31, 2004; For California, see Medi-Cal Redesign Website, *at* <http://www.medi-calredesign.org/overview.aspx> (last visited June 24, 2004).
71. All of the presidential candidates who had a broad-based health care reform proposal included a substantial role for Medicaid (or a program with similar elements), with some anticipating a considerably expanded role as compared to today, see, "Side-by-Side Summary of Presidential Candidates' Proposals for Expanding Health Insurance Coverage," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2003); S.R. Collins, K. Davis, and J. Lambrew, "Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals," *Commonwealth Fund* 671(2004): 7-10.
72. S.R. Collins, et. al, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage, Commonwealth Fund* 626 (2003); This study found that fifty-three percent of workers making less than ten dollars an hour were eligible for their employer's health plan, as compared to eighty-seven percent of workers making more than fifteen dollars an hour.
73. Tax credits have been advanced as one possible way to help low-income people afford private coverage, and refundable tax credits have been proposed as a way to extend this subsidy to the millions of Americans whose incomes are too low to owe income tax (or to owe an amount of tax that would exceed the potential subsidy amount). A number of structural issues would have to be resolved for a refundable tax credit system to work well as a way to finance health insurance for low-income people; see L. Blumberg, *Health Insurance Tax Credits: Potential for Expanding Coverage* (Washington, D.C.: The Urban Institute, 2001). To date, the refundable tax credit created under the recent Trade Act has had limited take up, in part due these structural problems; as of the end of 2003, only about 3.6 percent of the workers who were potentially eligible had enrolled in the advance credit. S. Dorn and T. Kutyla, "Issue Brief: Health Coverage Tax Credits Under the Trade Act of 2002," *Commonwealth Fund* 721 (2004): 3; see also, R. Pear, "Sluggish Start for Offer of Tax Credit for Insurance," *New York Times*, January 25, 2004.
74. J. Hadley and J. Holahan, *supra* note 52.
75. Congressional Budget Office (CBO), *March 2004 Medicaid Baseline* (Washington, D.C., United States Government Printing Office, 2004); Center for Medicare and Medicaid Services (CMS), *National Health Care Expenditures Projections: 2003-2013* (Washington, D.C.: CMS, 2004).
76. "If God did not exist, it would be necessary to invent him," *Epitre a l'Auter du Livre des Trois Imposteurs*, November 10, 1770, quoted in J. Bartlett, *Bartlett's Familiar Quotations* 15th ed. (Boston: Little, Brown, 1980): 344.
77. Some new tools could help states contain Medicaid costs without compromising the quality of care; for example, disclosure to state Medicaid agencies of drug pricing that would allow states to improve their ability to set drug prices. Some changes would need to occur within the Medicaid program while other measures go beyond Medicaid and would help Medicaid as well as other payers contain costs.
78. L. Ku, *The Medicaid-Medicare Link: State Medicaid Programs Are Shouldering a Greater Share of the Costs of Care for Seniors and People with Disabilities*, (Washington, D.C.: Center on Budget and Policy Priorities, 2003).
79. B. Bruen and J. Holahan, "Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2003).
80. Federal minimum income eligibility standards for parents vary by state; for parents with no earned income, they range from thirteen percent of the federal poverty line in Alabama to sixty-seven percent of the federal poverty line in Connecticut (based on the 2004 Federal poverty line). Authors' calculations based on data on July 1996 eligibility levels from U.S. House of Representatives, Committee on Ways and Means, 104th Cong., *Background Material And Data On Programs Within The Jurisdiction Of The Committee On Ways And Means (Green Book)*, Table 8–12: 437.
81. "Churning" refers to loss of coverage, often due to administrative requirements, followed by re-enrollment in the program. This not only disrupts coverage and care, but also results in added costs. G. Fairbrother, H.L. Park and A. Haidery, *Policies and Practices That Lead to Short Tenures in Medicaid Managed Care*, Draft, (Princeton, NJ: Center for Health Care Strategies, 2003); P.F. Short, D.R. Graefe, and C. Schoen, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," *Commonwealth Fund* 688 (2003): 9-10.
82. States should, of course, be permitted to adopt procedures that assure program integrity. States have generally found that streamlined processes do not interfere with states' ability to take a variety of measures (including data matches, using information from other state programs, and random audits) to assure that people who are enrolled are eligible for the program. D. Cohen-Ross and L. Cox, "Preserving Recent Progress in Health Coverage for Children and Families: New Tensions Emerge," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2003).
83. Research has repeatedly shown that premiums and cost sharing, if set too high, will deter low-income people from enrolling in coverage and accessing necessary care; See, J. Hudman and M. O'Malley, "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2003); L. Ku, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid*, (Washington, D.C.: Center on Budget and Policy Priorities, 2003); R. Tamblyn, et. al., "Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons," *Journal of the American Medical Association* 285, no. 4 (2001): 421–429; HRSA State Planning Grant Consultant Team, *Income Adequacy and Affordability of Health Insurance in Washington State* (University of Washington Health Policy Analysis Program, Rutgers University Center for State Health Policy, RAND, William M. Mercer, Inc., The Foundation for Health Care Quality, 2002). The recent experience in Oregon where more than half of the poor adults who were subject to premiums dropped out of the program shows that even relatively modest premiums (in this case, premiums ranged from six dollars to twenty a month) can be too high for poor people; J. McConnell and N. Wallace, *Impact of Premium Changes in the Oregon Health Plan (February 2004)*, Oregon Health Research & Evaluation Collaborative, *at* <http://www.ohpr.state.or.us/OHREC%20welcome2_files/Reports%20and%20Briefs/Impacts%20of%20Premiums%20-%20FINAL.pdf > (last visited July 1, 2004).
84. For the list of HHS waiver initiatives, see *supra* note 59. For a description of the new Health Insurance Flexibility and Accountability waiver initiative and some of the implications of the new waivers, see C. Mann, "The New Medicaid and SCHIP Waiver Initiatives," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2002); C. Mann, S. Artiga and J. Guyer, "Assessing the Role of Waivers in Providing New Coverage," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2003); S. Artiga, J. Guyer and C. Mann, *supra* note 63; and other waiver reports and fact sheets prepared by and for the Kaiser Commission on Medicaid and the Uninsured, *at* <http://www.kff.org/medicaid/waivers.cfm> (last visited June 24, 2004).
85. J. Guyer, "The Financing of Pharmacy Plus Waivers: Implications for Seniors on Medicaid of Global Funding Caps," *Kaiser Commission on Medicaid and the Uninsured* (Washington, D.C.: Kaiser Family Foundation, 2003).
86. Recently the far-reaching nature of waiver activity has attracted critical attention from the Congress as well. See, Letter from Senators Charles Grassley and Max Baucus to CMS Director Mark McClellan, June 16, 2004.

COMMUNICATIONS

Statement
of the
American Pharmacists Association

Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net

Submitted to the
Senate Committee on Finance

June 29, 2005

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Statement of the American Pharmacists Association (APhA)
To the Senate Committee on Finance

On "Medicaid Waste, Fraud and Abuse:
Threatening the Health Care Safety Net"

June 29, 2005

The American Pharmacists Association (APhA) appreciates the opportunity to present the views of the nation's pharmacists on the issue of Medicaid reimbursement for prescription drugs. APhA, founded in 1852 as the American Pharmaceutical Association, represents more than 52,000 pharmacist practitioners, pharmaceutical scientists, student pharmacists, pharmacy technicians, and others interested in advancing the profession.

The public pressure to address the rising cost of prescription drugs has prompted Congress to examine the current system of reimbursing pharmacies for prescription drugs. This charge carries with it a significant responsibility – to determine how to fairly reimburse pharmacies for the products they acquire and for the pharmacist services required to supply the product to patients. The reimbursement system is currently quite complicated and will require a comprehensive review to reach a fair resolution to the payment issues.

Any resolution, while addressing payment for drugs, must also address underpayment — or complete lack of payment in some instances — for pharmacists' professional services. Similar to the Committee's solution to Medicare Part B reimbursements to oncologists, it is time to reform the system to recognize the importance of pharmacist services and to adequately compensate for those services. Like hospitals, pharmacies have charges associated with using the facility, for products used, and for the services provided. Mr. Vito of the Office of Inspector General stated in his June 29th statement to the Committee, "states must reasonably reimburse pharmacies for prescription drugs provided to Medicaid beneficiaries". The challenge is defining that reimbursement amount.

The Fallacy of 'Paying Too Much'

It is important to clarify a misstatement that has been repeated in this dialogue on reforming Medicaid payment for drugs. It has often been said that Medicaid 'pays too much' for drugs. However, this general statement ignores some important facts that must be considered when deliberating on this subject.

It is irresponsible to ignore the fact that providing prescription drugs to patients involves several cost factors above and beyond simply the cost of the product. These cost factors include a fair profit, business overhead, and the costs associated with providing a pharmacist's medication expertise. The number that is often referred to as 'too much' may indeed reflect that Medicaid may pay more than a pharmacy's actual acquisition cost for the drug product. But that amount could be appropriate and far from 'too much' when one considers that the total amount paid incorporates several cost factors.

Historically, and regrettably, pharmacist services have been partially compensated through the "spread" between the acquisition cost for the product and the sales price. In an attempt to control the rate of growth of their program's prescription drug costs payors of prescription drug benefits, including State Medicaid Directors, have simply cut the reimbursement for the drug product. While seemingly logical, program reforms that cut reimbursement for the product without adequately compensating for the pharmacists' services required to supply the product are flawed.

It represents a practice that fits into Senator Grassley's category of "real problems that need to be fixed[1]." Simply "solving" the problem by cutting reimbursement for the product does not appropriately take into account each of the elements that are not otherwise paid for by Medicaid. Until Medicaid begins compensating pharmacists for their services directly and stops linking a payment for pharmacist services with the drug product, it will continue to be appropriate to create a 'spread' on the product to represent those otherwise uncompensated cost factors.

Adopting a Fair Formula
In recent discussions, Members of Congress and others interested in reforming Medicaid payment for drugs have suggested that any new payment formula must meet the following criteria: 1) reimbursement closely reflects pharmacies' actual acquisition cost; 2) the basis for product cost calculations can be verified; 3) the components of the product cost calculations are defined in law; 4) and there are penalties for false reporting.

While APhA generally supports these ideas of greater transparency and accountability, we cannot lose site of the fact that any formula, in order to be fair, must account for all elements associated with dispensing medications. Any payment formula must reflect a pharmacy's true costs, which are costs above and beyond simply the purchase price of the drug product. Any negative changes to reimbursement for prescription drugs in the Medicaid program will impact patients' access to both prescription medications and pharmacist services. Although pharmacists are dedicated to helping their patients, if pharmacists are unable to acquire products at or below reimbursement rates, many pharmacies will be forced to discontinue providing these drug products to their patients.

Ideally, a fair reimbursement formula would address several key issues. A fair formula would reflect current prices and would not be based retrospectively, a problem inherent in some formulas such as Average Sales Price (ASP). The formula would address 'class of trade' issues inherent in the pharmacy industry. Because retail pharmacy is considered a separate 'class' than mail service, hospital, or other pharmacies, retail does not have access to the lower drug prices or the same rebates or discounts as other classes of the trade. Therefore, any proposal that 'blends' or 'averages' purchasing prices, rebates and discounts of the various classes of trade automatically puts retail pharmacy at a disadvantage. That disadvantage could result in retail pharmacies dispensing every Medicaid prescription at a loss. It is also important to adopt a formula that creates appropriate incentives for pharmacists to dispense generic medications. Some formulas, such as ASP, create economic incentives for pharmacists to dispense brand drugs, often a more costly product for the Medicaid program to cover. Generic use is a cornerstone of good pharmacy management and incentives, not disincentives, should be created for their use.

Finally, any fair reform package would make the source of savings proportional to the costs attributable to that source. Medicaid costs continue to rise even though over the past several years Medicaid drug payments to pharmacies have been cut. This trend reflects the fact that drug spending is being driven by increasing drug product costs and increasing drug use not dispensing fees or pharmacy payments. Reductions in reimbursement rates and dispensing fees for pharmacies only impact a small percentage of the overall costs to provide a pharmacy benefit. These reductions do not affect the main source of the cost — the drug product. Any fair reform proposal must not require pharmacy to bear the entire burden of savings. Pharmacy should only be asked to produce savings proportional to their share of the costs.

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[1] Opening Statement of U.S. Senator Chuck Grassley of Iowa, Chairman, Senate Committee on Finance, Hearing, Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net, Tuesday, June 28, 2005

What is Enough?

The Committee faces the distinct challenge of developing fair compensation for the drug product, pharmacists' dispensing-related services, and administrative costs associated with the delivery of the drug and claims submission. The preparation and dispensing of a drug product is a multi-step process that contains several different components, each of which adds a cost to the process. For example, after the beneficiary presents a prescription at the pharmacy, the pharmacist processes the prescription (entering information into the pharmacy's computer system, correcting clinical conflicts, complying with third party payor requirements, resolving conflicts with pharmacy benefit managers, etc.), prepares the order (retrieving the drug, selecting/preparing the correct amount, preparing the label, etc.), and delivers or dispenses the product to the patient (transferring the product to the patient, preliminary counseling the of patient, handling the financial transaction, etc.).[2]

As you look to make these changes, we recommend that you consider the payment reforms to Medicare Part B Congress included in the Medicare Modernization Act. These revisions establish a new payment methodology that attempts to move away from using the "spread" to cover the costs associated with supplying the drug product, to a system that separately reimburses for the cost to acquire the product and for the costs associated with administering and/or supplying the product. It is a very similar problem to the one the Committee is trying to address today. As we have expressed, APhA has underlying concerns with the ASP payment model now being used in Medicare Part B; we also have specific concerns with the current Medicare Part B reimbursement rate of 106% of ASP, which may not adequately cover the costs to obtain the product. However, the Medicare Part B reforms support adoption of a separate pharmacy supplying fee that better reflects the costs of providing these drugs. Similar to the increase in the drug administration fee for physicians, the Medicare Part B pharmacy supplying fee indicates that current product reimbursement payments were inadequate to cover a pharmacy's costs.

Before establishing a Medicaid dispensing fee, APhA recommends the Committee undertake a careful review and study of the costs to provide the medications and services to Medicaid beneficiaries; these costs vary based on the product and the variables associated with its provision. Such work should include a review of the various cost-to-dispense studies done across the country. As the Committee considers overhauling the payment system, these analyses are critical to ensuring fair compensation and viability of the pharmacy industry. Moving to a cost-based system, at a minimum, requires an evaluation of all costs associated with providing Medicaid patients a service, including costs of dispensing medications. To ensure that the amount is adequate or 'enough' this review must be conducted annually to reflect inflation.

Increasing ROI Through "MTM"

As the Committee develops its reform proposal, particularly the proposal that addresses the long-term stability of the Medicaid program, we draw your attention to a crucial component of drug delivery that is separate from payment for the product and payment for pharmacists to supply the product – medication therapy management (MTM) services.

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[2] Pharmacy Activity Cost and Productivity Study. Performed by Arthur Anderson LLP for the National Association of Chain Drug Stores Education Foundation. November 1999. Pg. 6.

Studies have shown that simply providing a drug product to a beneficiary isn't always enough to help the patient manage their illness. The chronically ill in particular benefit greatly from pharmacist interventions to improve compliance with medication regimens. Modifications to the payment system must consider the role of pharmacists in ensuring appropriate medication use. As frustrating as rising prescription budgets are to payors, we must recognize that many elements of drug costs cannot be controlled (i.e. the cost of raw materials). MTM services, while unable to impact the uncontrollable costs, are an effective way to control the rate of growth of a prescription drug budget by helping to assure that the medications do what they should and bring value to both the patient and payor.

Pharmacists provide services such as patient training and education, resolution of medication-related problems, programs that enhance patient understanding of medication utilization, improve compliance, and reduce the potential for adverse drug events, and case management and disease management. If these services are ignored, Congress will reduce their return on investment in providing prescription drugs. Paying for drugs which do not cure a disease or an infection because of inappropriate use costs the health care system more money due to hospitalizations, emergency room visits, and other procedures. Paying pharmacists to provide valuable medication therapy management services will save money in the long term. Medicaid payment reforms should include compensation for pharmacist-provided medication therapy management services.

Examples of pharmacist-provided MTM services include:

- Confirming the patient understands how to use the medication and is compliant with the medication regimen. This can involve face-to-face consultations and/or phone calls to the patient on a monthly or more frequent basis to assess compliance.
- Individualized case management to ensure patients adhere to adjunct medications that prevent side effects and decrease risk factors, such as serious infections, dyslipidemia, and hypertension
- Performing a comprehensive medication review to identify, resolve, and prevent medication related problems, including adverse drug events;
- Selecting, initiating, modifying, or administering medication therapy;
- Monitoring and evaluating the patient's response to therapy, including safety and effectiveness.

Next Steps

Thank you for the opportunity to provide comments on this important issue. APhA supports the Committee's effort to create a more transparent system of paying for medications that also provides appropriate and adequate payment to cover pharmacists' costs to acquire a product, to supply the product, and to provide necessary dispensing related professional services. If Congress adopts a payment system that does not adequately cover pharmacies' costs, including those costs traditionally placed within the "spread" such as the dispensing-related services provided by pharmacists, many will be forced to discontinue providing services to Medicaid beneficiaries.

APhA recommends that the Committee work with pharmacist and pharmacy organizations to establish a payment formula. To that end, we offer our assistance to the Committee as you continue your valuable work to determine appropriate payments for prescription medications for the Medicaid program.

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Attn: **Senate Committee on Finance**
Editorial and Document Section, Room SD 203
Re: **Response of Caremark Rx, Inc. to the Testimony of Patrick J. O'Connell on June 29, 2005**
"Medicaid Waste, Fraud and Abuse: Threatening the Health Safety Net"

Caremark would like to respond to the June 29, 2005 testimony of Patrick J. O'Connell before the Senate Finance Committee during the hearing entitled "Medicaid Waste, Fraud and Abuse: Threatening the Health Safety Net." In that testimony, Mr. O'Connell described certain efforts taken by his department, the Medicaid Fraud Section of the Texas Attorney General's Office, to seek reimbursement from drug companies. He recounted successes in achieving large settlements with drug companies accused of defrauding the Texas Medicaid agency, and then abruptly segued his testimony into mention of a "recent" case filed by his office against Caremark. The "recent" case to which he referred is a *qui tam* action filed in 1999 by a private relator under the False Claims Act ("Texas *qui tam*"). The case remained under seal for nearly six years until it was activated in May 2005 and Caremark was first served with a copy of the complaint.

The Texas *qui tam* is rife with numerous unsupportable allegations. The allegations seized upon by Mr. O'Connell's office are those involving Medicaid reimbursement for pharmacy claims paid for so-called "dual eligibles." Dual eligibles are the small number of Medicaid enrollees who also have pharmacy benefit coverage under private health plans. Mr. O'Connell inaccurately suggests that these are "Caremark plans," designed by Caremark and with insurance coverage provided by Caremark. They are not. Caremark is not a provider of insurance. Rather, the benefit coverage at issue is provided by plan sponsors, such as employers, unions and governmental entities. Caremark contracts with these plan sponsors to administer the pharmacy benefit component of the benefit plan.

Although Caremark may provide its customers consultation regarding plan design features, Caremark does not "develop" these plans. Rather, plans are designed and controlled solely by the plan sponsors. Under ERISA, plan sponsors are legally free to adopt, not adopt, or restrict plans in any way the sponsor sees fit, subject to the requirement that plans not take into account the fact that a plan beneficiary is eligible for or is provided medical assistance under Medicaid. Plan sponsors generally impose various limitations and restrictions upon plan participants. Of the multitude of such plan features, Mr. O'Connell singles out three particular restrictions which he finds objectionable: out-of-network restrictions, timely filing requirements and card presentation requirements.

The salient issue is whether such plan restrictions, lawfully selected by the plan sponsor, apply with equal force to Medicaid agencies when they submit claims for reimbursement to a private plan after having paid for benefits for a dual eligible. A dual eligible may choose for a variety of reasons to fill a prescription by presentation of his or her Medicaid card. When Medicaid pays the claim, since it is by law the payor of last resort, it takes an assignment of the dual eligible's rights under the private health benefit plan. As assignee, Medicaid becomes subrogated to the dual eligible's rights, and takes those rights subject to whatever limitations or restrictions apply to the plan beneficiary. Not surprisingly the two federal courts that have had this very issue before them have held that Medicaid as assignee obtains no greater rights than were held by its assignor, and that as assignee it stands in the plan participant's shoes subject to all defenses available against the participant. *See Belshe v. Laborers Health and Welfare Trust Fund for Northern*

California, 876 F. Supp. 216 (N.D. Cal. 1994); *Michigan Department of Social Services v. Shalala,* 859 F. Supp. 1113 (W.D. Mich. 1994).

For example, if the plan required a claim to be filed within six months of the prescription being dispensed, a claim filed eight months later would be denied if submitted by the participant. The same would be true if a provider submitted a claim for reimbursement to Texas Medicaid outside of the time limits set by Texas Medicaid. Likewise, if the plan had out-of-network or card presentation requirements and the plan beneficiary filled the prescription in a pharmacy not in the plan's network, or filled it without presenting his or her pharmacy benefits card, the beneficiary's claim for reimbursement would be denied by the claims processor when processing the claims for the plan sponsor. There is no basis for state Medicaid agencies to assert that the lawful plan limitations selected by plan sponsors are inapplicable to them.

State Medicaid agencies have a choice. They can elect to use "cost avoidance," under which the state Medicaid agency denies a claim at the point of sale if it has determined that the Medicaid enrollee also has private insurance coverage. Because the cost avoidance option is a more efficient means of addressing third-party liability, state Medicaid agencies are required to use cost avoidance as a precondition to receiving federal funding for their Medicaid programs, unless the agency obtains a cost avoidance waiver from CMS. *See* 42 C.F.R. § 433.138. Indeed, in its Medicaid Plan submitted to CMS, Texas Medicaid chose to use cost avoidance for provider claims. However, it sought a waiver to use the exponentially less cost-effective "pay and chase" method for pharmacy claims, under which it pays the benefit first even if it knows the Medicaid enrollee has private insurance and then chases the reimbursement from the third party afterwards.

Unlike cost avoidance, which requires the use of available private insurance at the point of sale, the pay and chase methods gives pharmacists and beneficiaries the choice of using Medicaid coverage instead of private coverage. Pharmacists have an incentive to submit claims to Medicaid because Medicaid generally reimburses pharmacists at a higher rate than private health benefit plans. Beneficiaries also have an incentive to use Medicaid, even when they are covered by a private health benefit plans, because Medicaid generally does not impose a co-payment obligation on the beneficiary or may impose a co-payment that is lower than the co-payment requirement in the private health benefit plan.

The OIG has recognized the inefficiencies inherent in the pay and chase system. In a recent report entitled "CMS Oversight of Cost-Avoidance Waivers," the OIG concluded that regional CMS offices have granted pay and chase waivers too freely without requiring state Medicaid agencies to demonstrate their cost-effectiveness. *See* February 2004 OIG Report, CMS Oversight of Cost-Avoidance Waivers, OEI-03-00-00031. In an earlier report, OIG recognized that use of the pay and chase method for pharmacy claims has caused money to virtually hemorrhage from state Medicaid coffers. *See* August 2001 OIG Report, Medicaid Recovery of Pharmacy Payments from Liable Third Parties, OEI-03-00-00030. The pay and chase method is not only inefficient, but it also results in eliminating opportunities for reimbursement that are available to state Medicaid agencies when they elect to cost avoid.

Many states require doctor's offices to determine whether third party insurance is available before submitting a claim to Medicaid. However, some states choose not to impose the same obligations on pharmacists, despite the fact that state laws require retail pharmacies to collect and maintain detailed information on the persons whose prescriptions they fill. Therefore, as a practical matter, a retail pharmacy is more likely than a doctor's office to have a sophisticated computer database to access information about third-party coverage. Given the large amount of money at stake, it would seem reasonable for states to take the simple step of requiring retail pharmacists to use the information they have already collected to determine third-party coverage, as they often do with other providers. If this step were taken, state Medicaid agencies would not be put in the position of having to request reimbursement from PBMs.

Further, the Congressional action requested by Mr. O'Connell—that PBMs such as Caremark be required by law to report to CMS on a quarterly basis their covered lives—is nothing more than what is currently available to Medicaid agencies when they choose to cost avoid. In fact, Texas Human Resources Code §32.042 already requires insurers, including employer-sponsored benefit plans, to share information about its covered beneficiaries with Texas Medicaid upon request, obviating the need for federal legislation on the subject. However, if such federal legislation were to be enacted, a concomitant requirement should be imposed on Medicaid to access the data base and not pay pharmacy claims for dual eligibles who elect not to utilize available private coverage. As the OIG has concluded after an extensive investigation, state Medicaid agencies should not be able to obtain cost-avoidance waivers with such ease, but should be required in most circumstances to use the information they already have on their enrollees to avoid paying claims for dual eligibles on the front end.

Any rules Congress seeks to impose should likewise shield PBMs and plans that make a good faith effort to comply with the requirement of reporting covered lives from any liability for claims for reimbursement submitted by Medicaid which fail to comply with the restrictions and limitations imposed on the plan beneficiary from whom Medicaid has taken an assignment of benefits. That way, the shortfall in collection of reimbursement by Medicaid falls on the parties best able to protect against it—the dual eligibles who elect to utilize Medicaid instead of their available private coverage and the Medicaid agencies who receive a benefit from the existence of the plans and have the means to make a determination of eligibility before honoring a dual eligible's claim.

In closing, much of the losses that state Medicaid agencies have incurred on pharmacy claims are the direct result of their own decision to pay and chase pharmacy claims, even though they have been advised by the OIG of the tremendous risks inherent in such a decision. Solutions to many of the Medicaid reimbursement issues are available through the state legislatures, and the simplest solution of all is the use of cost avoidance, as required by federal law as a precondition to receiving federal funding, for pharmacy claims.

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Senate Finance Committee Hearing on Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net

June 28, 2005

Statement of Larry S. Gage
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The National Association of Public Hospitals and Health Systems (NAPH) appreciates this opportunity to submit a statement for the record regarding Medicaid intergovernmental transfers (IGTs), which were among the topics addressed during the Committee's recent hearing on waste, fraud and abuse in the Medicaid program. NAPH supports efforts to eliminate waste, fraud and abuse in the Medicaid program in order to ensure that federal funds are not diverted from patient care and other intended uses. Yet, as the Committee recognizes, Medicaid financing is a particularly complex area and any changes must be weighed carefully. NAPH does not condone financing mechanisms in which the use of IGTs results in the "recycling" of federal funds. However, IGTs can also be a valuable mechanism for governmental entities other than the state to appropriately share in the non-federal cost of essential and legitimate services and payments. We are therefore opposed to restrictions on IGTs that would deprive safety net hospitals of legal and appropriate sources of funding for their vital missions and services. In particular, restrictions on IGTs or arbitrary and ill-conceived limits on Medicaid payments could eliminate a key source of financial support for public hospitals and health systems.

As the Finance Committee attempts to identify $10 billion in savings over the next five years as well as longer-term Medicaid reforms, we urge you to recognize the importance of legitimate Medicaid financing approaches and to carefully weigh the potential impact that any effort to curtail Medicaid spending will have on safety net providers and their patients. In the near term, NAPH supports efforts to identify Medicaid savings by addressing pharmaceutical pricing concerns and by implementing new and innovative methods to improve chronic care management.

NAPH represents more than 100 of America's metropolitan area safety net hospitals and health systems. The mission of NAPH members is to provide health care services to all individuals, regardless of insurance status or ability to pay. Medicaid provides essential support for safety net health care providers who provide access to care for millions of Medicaid and uninsured individuals, train many of our nation's physicians, nurses, and other health care professionals, and provide community-wide services like trauma care, burn care, and emergency preparedness in communities across the country.

Approximately 60 percent of the patients served by NAPH members are either Medicaid recipients or patients without insurance. Medicare covers another 21 percent of the patients of NAPH members. Our members thus rely on governmental sources of financing to cover over three-quarters of their costs. Medicaid is a major source of essential financing for America's institutional health safety net – 37 percent of the net revenues of NAPH member hospitals are Medicaid revenues. Without adequate Medicaid support, most NAPH members simply would not survive, notwithstanding the successful strategies that public hospitals have implemented over the last two decades to increase both their self-sufficiency and their ability to compete with their private counterparts. NAPH members also provide nearly 25 percent of the nation's uncompensated hospital care while representing only two percent of acute care hospitals in the country.

Consistent with Medicaid law, many states use IGTs to help finance essential supplemental payments for safety net providers. Medicaid Disproportionate Share Hospital (DSH) payments and other Medicaid supplemental payments allow NAPH members to serve large volumes of Medicaid recipients and persons without insurance. NAPH members receive billions of dollars in Medicaid DSH payments, which were created by Congress to "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs." At the same time, many NAPH members also provide a substantial proportion of the non-federal share of such DSH payments. This is not abusive; it is a legitimate allocation of responsibility for covering the non-federal share of Medicaid payments between state and local governments. Such sharing of the financial burden between states and local governments is often critical to enabling states to provide DSH and other forms of critical support to safety net providers. Proposals to severely restrict IGTs would have a crippling impact, particularly on the safety net. Our members, who currently manage to stay afloat with average margins of negative 0.3 percent (compared to 4.5 percent industry-wide), would see their margins plummet to negative 9 percent if they did not receive Medicaid DSH payments. DSH quite literally permits our hospitals to stay in business and provide the care that they do, because no hospital could sustain the kinds of losses we would incur without DSH.

The use of local as well as state funds for the non-federal share of Medicaid expenditures has been a fundamental part of the Medicaid program since its inception. Efforts to reform IGTs should respect the existing and historical local role in financing the Medicaid program. Medicaid is a partnership between the federal government, states and localities. The Medicaid statute has always referred to the "federal" share and "non-federal" share, not the state share. Federal Medicaid law and regulations explicitly ***permit*** entities other than states to contribute some portion of the non-federal share of Medicaid payments through IGTs and allow states to fund ***up to 60%*** of the non-federal share of Medicaid costs through such expenditures. The Medicaid statute also permits not only local governments but also local government health care providers to contribute the non-federal share.

NAPH agrees with members of Congress and the Administration that federal Medicaid funds should not be used to generate additional federal Medicaid funds. Funds transferred by a public entity for use as the non-federal share of Medicaid payments should be a true contribution of local governmental funds. However, when NAPH members transfer public funds for care for the poor, the Medicaid statute recognizes that contribution as a real contribution and commits the federal government to provide federal Medicaid matching funds. These are not "financing schemes" designed to defraud the federal government. They are congressionally-approved mechanisms for allowing states to claim federal matching payments related to public funds spent on health care services to low income and vulnerable patients.

Legislative and regulatory changes have already addressed Medicaid financing abuses. Although a few states in the past took advantage of IGTs by using them to finance excessive payments to public providers that were subsequently returned to the state, as the Committee heard, Congress and the Centers for Medicare and Medicaid Services (CMS) have effectively curtailed the opportunity for such abuse by placing strict limits on payment amounts. Congress has imposed limits on statewide DSH allotments, has capped DSH payments to individual hospitals based on unreimbursed costs and has mandated changes to upper payment limit (UPL) regulations to prevent abuse. The UPL changes alone have reduced federal payments by an estimated $85 billion. While many states still pay providers in excess of Medicaid costs under the current UPL regulations, these payments are far more limited than allowed in the past and are essential to ensure access to the full range of services for Medicaid recipients.

Even more recently, CMS has undertaken careful review of state financing and has worked with a large number of states to eliminate questionable financing practices. Although the President's budget included nearly $5 billion in Medicaid savings from curbing state practices where states inappropriately "recycle" federal dollars to draw down additional federal funds, CMS is already working with states to eliminate these state practices even in the absence of additional regulatory or legislative authority. A CMS chart classifying states' uses of IGTs into several categories was recently circulated to Congress. According to the chart (in which some states with multiple IGT arrangements are listed in more than one category) as of March, 20 states had agreed to revise IGTs to remove identified recycling and according to recent testimony by Dennis Smith, Director of CMS' Center for Medicare and State Operations, that number has now reached 26 and there are now only 7 states where CMS has identified potential recycling. NAPH is concerned that legislative efforts to restrict IGTs beyond current CMS initiatives could have an unintended impact on legitimate IGTs being used to support public providers and their patients.

As CMS itself has acknowledged, most of the potential "savings" in the system from curbing IGT abuses have already been largely realized. As a result, any savings from legislative action further restricting IGTs could be derived only from a small handful of states without seriously jeopardizing access to care for Medicaid and low-income patients. Regulatory changes related to upper payment limit payments have already cut $85 billion from the Medicaid program and addressed some of the Medicaid "overpayment" issues that have been described to the Committee. Additional reforms related to IGTs in the name of reducing waste, fraud and abuse will primarily result in reduced payments to providers serving the neediest patients. Restrictions on the use of local funds will, in many states, eliminate the supplemental Medicaid payments – including DSH – that enable NAPH hospitals and other safety net providers to sustain their missions. Congress should avoid adopting broad changes without considering the consequences and the harm to the very patients Medicaid is supposed to help.

* *

Medicaid has become our nation's primary vehicle for supporting safety net health systems. As the number of Americans living in poverty rises, strengthening the Medicaid program is critically important and any policy changes must take into consideration the potential impact on safety net providers who shoulder the burden of caring for our nation's poor and uninsured. Medicaid savings should be attained through proposals that not only save money but also improve health care quality and access. For example, NAPH supports efforts to promote effective chronic care management practices that will improve patient care and drive down Medicaid costs over time. NAPH also supports efforts to control Medicaid pharmacy costs by extending the 340B drug pricing program to the inpatient setting and by increasing the flat rebate paid to Medicaid by drug manufacturers. At the same time, it is critical to ensure that proposals to restructure pharmacy reimbursement do not achieve savings solely from community pharmacies; if these essential safety net providers cease to participate in Medicaid, current Medicaid recipients may experience difficulty accessing essential services.

NAPH appreciates the opportunity to share our observations about critical Medicaid financing issues and looks forward to working with the Committee to develop solutions to the problems confronting our nation's poor and uninsured and the safety net providers that serve them.

NCCNHR National Citizens' Coalition for Nursing Home Reform

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Statement for the Record of the National Citizens' Coalition for Nursing Home Reform

Medicaid Waste, Fraud and Abuse: Threatening the Health Safety Net

U.S. Senate Committee on Finance
June 28 - 29, 2005

The National Citizens' Coalition for Nursing Home Reform appreciates the opportunity to submit a statement for the record providing nursing home consumers' perspectives on Medicaid fraud, waste, and abuse. The fair, honest and efficient operation of Medicaid is an issue of overwhelming importance to our constituents, because two-thirds of nursing home residents depend on financial assistance from Medicaid; and the vast majority of all Americans who live in nursing homes benefit from Medicaid's quality standards and an enforcement system designed to ensure that all residents' health, safety, rights and quality of life are protected. The need for a public long-term care safety net is increasing with the aging of the population, and NCCNHR is eager to participate in a thoughtful public dialogue about how to preserve Medicaid's benefits and ensure that elderly and disabled Americans now and in the future will have access to the services they require.

Nursing home residents and other consumers of long-term care services have long been indebted to Senator Grassley for his strong commitment to eliminating practices in the long-term care industry that divert Medicare and Medicaid funds from providing care and result in severe abuse, neglect and death of beneficiaries. NCCNHR commends the Committee for its efforts through these hearings to identify ways to improve the federal and state governments' ability to investigate and prosecute abusers who cost Medicaid millions of dollars and cause immeasurable suffering among nursing home residents. The False Claims Act has been particularly effective where it has been used to help states and the federal government reclaim misspent public funds while putting bad providers out of business or under the surveillance of court monitors. For example:

- On May 18 of this year, Hillcrest Healthcare, Inc. of Connecticut agreed to pay $750,000 in civil penalties to settle federal and state charges that it had not provided care required by Medicare and Medicaid. It had already paid a $10,000 fine after pleading *nolo contendere* to a manslaughter charge related to the death of a resident from a septic infection allegedly caused by improperly treated bedsores. The U.S. Attorney said the resident who died was also suffering from

NCCNHR is a nonprofit membership organization founded in 1975 by Elma L. Holder to protect the rights, safety, and dignity of America's long-term care residents.

malnutrition, anemia, and dehydration – problems he said were suffered by "many" other residents in the facility because it was inadequately staffed and failed to follow plans of care. Connecticut's Attorney General said Hillcrest had "gross disregard for human life and the law—fatally neglecting patients, while at the same time billing the state for the very services it failed to provide."

- In September 2004, the U.S. Attorney's office for the Eastern District of Pennsylvania reached a civil settlement of $143,000 with Green Acres Rehabilitation and Nursing Center after alleging that it had submitted false claims to Medicare and Medicaid, providing inadequate services related to nutrition, medications, falls, and pressure ulcer care. The settlement also required the company to create a Quality of Care/Quality of Life Fund of $25,000 to purchase services and equipment to enhance residents' quality of life and to use consultants selected by the U.S. Attorney's office to oversee Green Acres' compliance with the settlement agreement.

- In November 2004, a Chicago nursing home agreed to pay $1.9 million to settle Medicaid fraud charges in which the state and federal government and a whistleblower alleged that residents were "routinely abused, neglected, mistreated, sexually assaulted, medicated as a form of punishment, unsupervised and otherwise untreated for their mental health, physical disability, and substance abuse problems."

- In 2001, Vencor Inc. agreed to pay the United States $104.5 million to settle a case in which the government charged that it had submitted false claims to Medicare, Medicaid, and other government programs. According to the Department of Justice, $20 million of the false claims were related to failure to provide care, including inadequate staffing, improper care of decubitus ulcers, and failure to meet residents' dietary needs.

Taxpayers Against Fraud (TAF) published a study in 2003 that reported that Medicare fraud recoveries between 1997 and 2001 were 12 times greater than federal Medicaid fraud collections, although Medicare outlays were only about twice federal Medicaid outlays. The study concluded there was no reason for these discrepancies because, "In January 2003, Medicaid joined Medicare on the General Accounting Office (GAO)'s list of federal programs at 'high risk for waste and exploitation.'"

Clearly false claims reforms – which can both increase the recovery of fraudulently spent funds and improve the quality of care provided – should be enacted by a Congress committed to reducing Medicaid costs. NCCNHR supports TAF's recommendation at this hearing to require states, as condition of receiving Medicaid matching funds, to enact their own false claims acts with whistleblower protections. This reform would encourage more whistleblowers to bring FCA cases against nursing homes that abuse Medicaid. Moreover, as TAF noted, such a change is necessary because the FCA only applies to fraud against the federal government and therefore does not cover states' share of Medicaid spending.

Individuals who practice legal estate planning should not be lumped with those who commit fraud and abuse simply because they follow congressionally approved rules that have been upheld by the courts. The testimony of Dr. Judith Feder of the Georgetown Public Policy Institute provides a wealth of evidence that most elderly Americans have only modest assets to shelter and that few do so – lending support to testimony that real Medicaid savings will be achieved by targeting providers who engage in fraud, not elderly citizens.

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To the extent that real abuses exist in Medicaid asset transfers, NCCNHR will work with members of Congress to identify them and will support amendments to current law. But we cannot support an approach that casts such a wide net that many moderate and even low-income Americans will lose Medicaid coverage at a time when they are old, financially destitute, severely disabled, and out of options. Arbitrarily extending the look-back period for asset transfers to five years and beginning the penalty period at the time of application for Medicaid will not affect the well-off who can afford estate planners – these arbitrary changes will hurt only those who, in their last years of independence, helped a relative who was in need or who was taking care of them; made a contribution to a church, synagogue or charity; or simply failed to keep immaculate records of their expenditures at a time when they were in failing health and mental capacity.

Nor can NCCNHR support aggressive estate recovery policies that would deny Medicaid beneficiaries' spouses and dependent children enough assets and income to live in dignity until their own deaths or spenddown to Medicaid eligibility. Pat McGinnis of California Advocates for Nursing Home Reform eloquently described the effects of California's punitive estate recovery program in a letter last year to a state legislator:

> The overwhelming majority of the 64 percent of California nursing home residents who have all or part of their costs of care paid for by the Medi-Cal program are not and never have been millionaires. They are former teachers, construction workers, housewives and gardeners, who have raised their children, saved their money and purchased homes, only to end up with the wrong disease. If they needed a heart transplant, they could enter acute care and Medicare would pick up the tab. Instead, they end up with Alzheimer's and in a nursing home, where the cost of even a substandard facility can exceed $5,000 per month.
>
> Most of these residents have spent their assets down to $2,000 - the limit for a Medi-Cal applicant. Many have spent hundreds of thousands of dollars on private pay before they applied for Medi-Cal. Many have husbands, wives or children who cared for them at home to keep them from a nursing home, only to see their own health deteriorate and with no alternatives to institutionalization. When they die, their survivors are faced with an estate claim on the family home which, if not paid, results in a lien with 9 percent annual interest.

There is an understandable desire on the part of governors not to provide Medicaid benefits to those who could pay their own way. However, Governor Warner and Governor Huckabee's inability to answer repeated questions before this Committee about the number of beneficiaries they allege are using estate planners to shelter assets suggests a willingness to rush into reforms that are poorly understood and will have unintended consequences. NCCNHR believes that many nursing homes would end up providing uncompensated care to residents who had run out of money and could no longer pay for their care themselves or qualify for Medicaid. Other residents would be discharged to hospitals, where Medicare would cover their care, or to community settings they could afford with limited incomes, whether or not they were licensed, provided adequate services, or were safe.

It is also understandable that providers such as Daniel O'Brien, who testified on behalf of Erickson Retirement Communities, are disappointed that they do not have access to the private assets of residents who have taken advantage of legal asset transfers. The kinds of practices Mr. O'Brien described in his testimony require an unbiased investigation to see whether people with substantial means are indeed evading the intent of Medicaid. NCCNHR does not, however, support changes to Medicaid that would allow providers to discharge residents because they qualify for Medicaid; require a third party to pay for their care; or impoverish spouses still living in the community. Medicaid should not sanction discrimination based on source of payment or allow eligible residents to use the program's benefits only when it is to the provider's advantage.[1]

There are many reforms that could improve Medicaid. Congress should examine, for example, the findings of a 2004 Brown University study that 40 percent of African American residents are in nursing homes with the lowest staffing levels, worst inspection records, and greatest likelihood of closing. It should reverse the Centers for Medicare and Medicaid Services' policy requiring Medicaid residents to be segregated when a facility does not certify all of its beds. NCCNHR is deeply concerned that the debate about the future of Medicaid, however, may be driven solely by efforts to cut costs and without careful regard for how our country is treating our "Greatest Generation" in the final days and years of their lives. We urge the Committee not to rush to make substantial changes in the Medicaid program but instead to engage in a thoughtful, *bipartisan* process to create a program that can meet present and future needs.

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[1] Often those who chafe at Medicaid's protections for beneficiaries enjoy the financial benefits of loopholes in the laws themselves. In a 2002 investigation of nursing home profitability, *U.S. News and Word Report* wrote that Erickson Retirement Communities' Oak Crest Village was a nonprofit that distributed "millions in management fees and other charges to affiliated for-profit ventures. . ." The magazine said the company received exemptions from corporate income taxes as well as access to tax-exempt financing, and it quoted experts saying that "Erickson's weaving of the nonprofit and for-profit entities, while legal, may violate the spirit" of a law intended for organizations like the Boy Scouts. Erickson's website lures prospective residents with promises that they and their heirs "save thousands of dollars—not just once, but twice" by depositing the proceeds from the sale of their homes into an Erickson account through which the residents and their estates avoid transfer taxes and other closing costs when they sell their home and again when their apartment is sold.

NCCNHR is a nonprofit membership organization founded in 1975 by Elma L. Holder to protect the rights, safety, and dignity of America's long-term care residents.

Statement by Sandata Technologies, Inc.

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Hearing on Medicaid Fraud, Waste and Abuse

Committee on Finance
United States Senate

June 28, 2005

Chairman Grassley, Ranking Member Baucus and distinguished Committee members:

We appreciate the opportunity to offer this statement on behalf of Sandata Technologies, Inc., a leading provider of advanced information technology solutions and services, in connection with the Committee's review of Medicaid fraud, waste and abuse. We commend the Committee's leadership on these issues and its efforts to ensure that limited taxpayer dollars are spent for their intended purpose of providing quality health care to individuals in need.

Health care services under Medicaid are increasingly delivered in home- and community-based settings, and patient demand continues to increase. In response, a number of proposals have been advanced in Congress and within the Administration to provide additional options for home- and community-based health care services to Medicaid-eligible individuals.

These proposals are designed to expand access to care in a cost-effective manner, recognizing the considerable constraints on available resources within the Medicaid-funded health care system. Improved information technology is a critical tool to accomplish these objectives, because it can help providers deliver quality services more efficiently while preventing the loss of limited health care dollars to waste, fraud or abuse.

To increase providers' utilization of information technology, however, it is critical for the federal government to work in partnership with the private sector to identify and eliminate regulatory obstacles that currently prevent its broader deployment. For example, the majority of States' Medicaid programs still impose outdated requirements for handwritten signatures on paper documentation, rather than accepting electronic records and electronic signatures. By contrast, Medicare accepts electronic records on a nationwide basis.

Once outdated regulatory barriers are removed, providers can rely on proven information technology such as "telephony for home care" to meet the growing needs of patients in home- and community-based settings. This technology allows providers to deploy a capable management infrastructure to reduce administrative costs and prevent waste or fraud, while ensuring that necessary services are delivered to achieve positive health outcomes for patients. With its accurate, real-time data collection capability, telephony significantly increases management visibility into field operations. It tracks tasks accomplished and matches them against the patient's plan of care, thereby providing a comprehensive, permanent audit record.

Based on these capabilities, telephony-based technology can play a critical role in addressing concerns identified by the Government Accountability Office (GAO) regarding deficiencies in government oversight under Medicaid home and community-based waivers. In a recent report,[1] GAO noted that "[n]o nationwide data are available on states' quality assurance approaches or the status of quality of care for beneficiaries served by waivers for the elderly, but concerns have been identified about the quality of care provided under many of these waivers."

Telephony for home care is a solution to the problems identified by GAO. It can ensure that patients receive the quality of care defined in their individual plan of care for the appropriate cost. Further, it delivers benefits to both payors and providers by reducing costs *without* cutting benefits to patients. For example, the City of New York's Medicaid-funded home care program is estimated to *save 5.5 percent of expenditures* from the difference between authorized hours and actual hours of service provided (see **Appendix**).

This service is available wherever telephone service is available, even under crisis conditions. During the 2003 blackout in the Northeastern United States, for example, the service continued to collect data to confirm that patients were being served. Given the distance involved in providing home- and community-based services to patient in rural areas, telephony is particularly effective as a management tool in those settings.

Given current budgetary pressures on Medicaid, it is essential to ensure that limited resources are targeted in the most cost-effective manner. Telephony for home care is a proven, reliable tool to achieve that objective, however, expansion of the technology is precluded by outdated State Medicaid rules barring use of electronic records. Federal leadership is needed to remove these barriers and give Medicaid-contracting providers the option of relying on electronic data records in lieu of paper documentation.

We look forward to working in partnership with the Committee to advance the use of information technology under Medicaid, strengthen the program and prevent fraud, waste and abuse. Thank you for your consideration of our views.

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[1] *Long-Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened*, GAO-03-576 (June 20, 2003).

Appendix: Telephony Automated Time and Leave Analysis Summary Report

Year	Monthy Average # Clients	Monthly Average Authorized hours	Monthly Average Paid/Actual Hours	Monthly Average Difference	Monthly Average % Saved	Annual $ Saved
2003	29,127	5,091,291	4,830,430	260,862	5.12	$44,445,845.25
2002	24,430	4,791,235	4,538,255	263,433	5.49	$39,960,482.71
2001	37,452	7,134,982	6,741,750	401,124	5.62	$58,961,328.13
2000	41,745	7,858,653	7,466,559	462,815	5.88	$65,263,303.59
1999	40,479	7,553,838	7,142,301	446,560	5.91	$62,540,106.31
1998	35,299	6,651,630	6,277,710	380,656	5.72	$54,452,099.33
1997	31,452	5,833,261	5,522,393	293,118	5.02	$42,837,393.42
1995 -1996	24,060	4,372,098	4,112,825	259,273	5.93	$34,844,347.50
Averages	**33,005**	**6,160,874**	**5,829,028**	**345,980**	**5.59**	**$50,413,113.28**

Total $ Savings $403,304,906.24

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